

THE BRITISH CHIROPODY JOURNAL

9, No. 1

JANUARY, 1954



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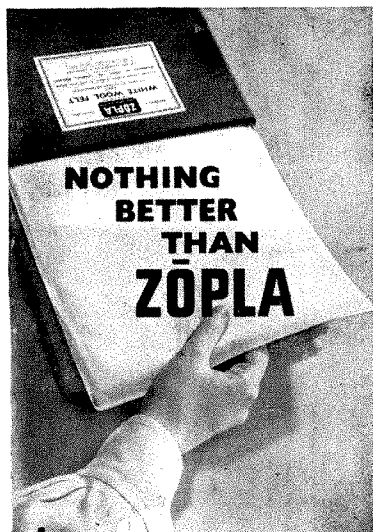
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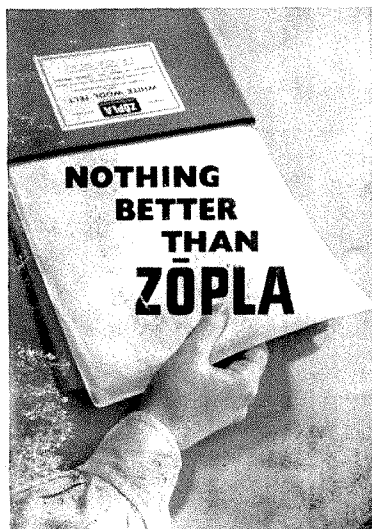
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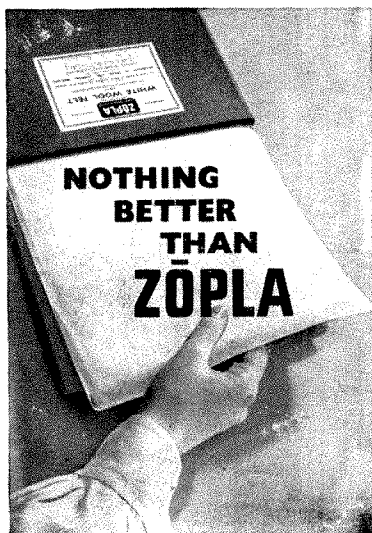
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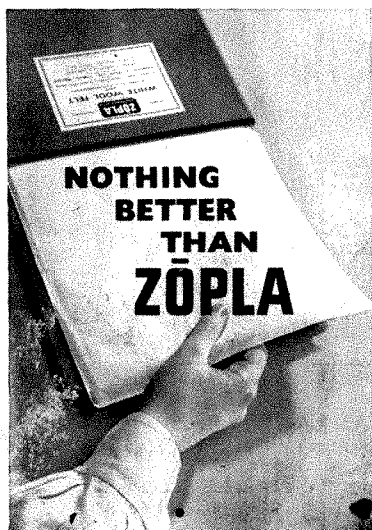
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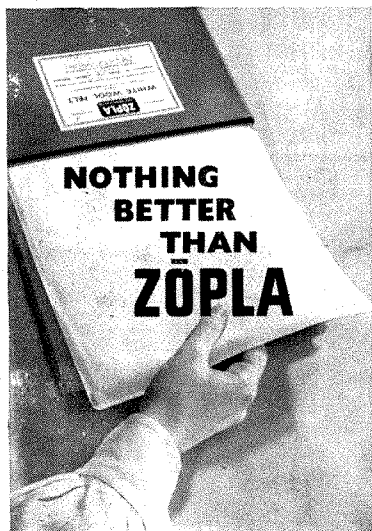


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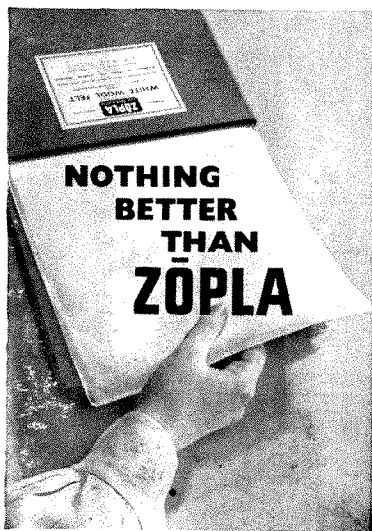
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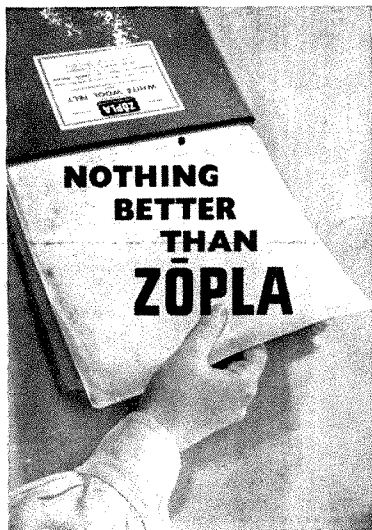


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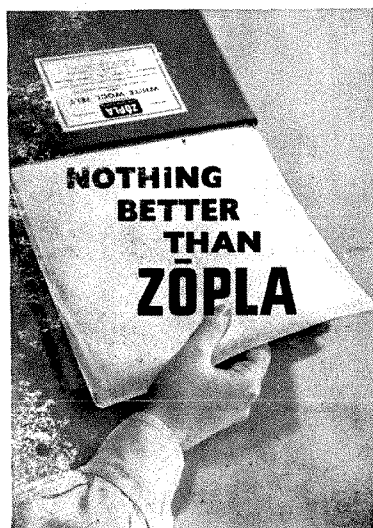
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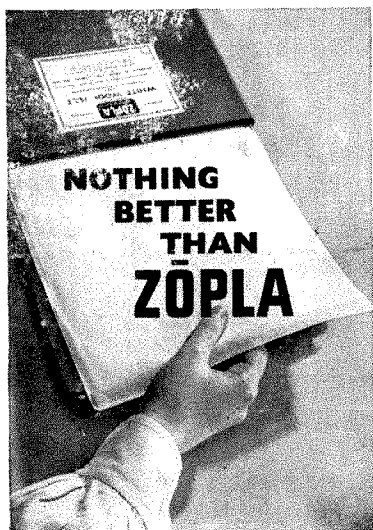


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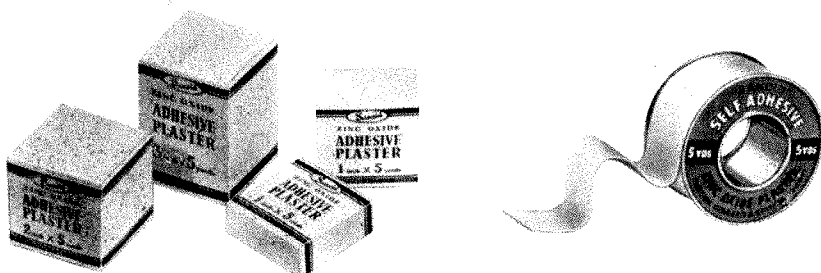
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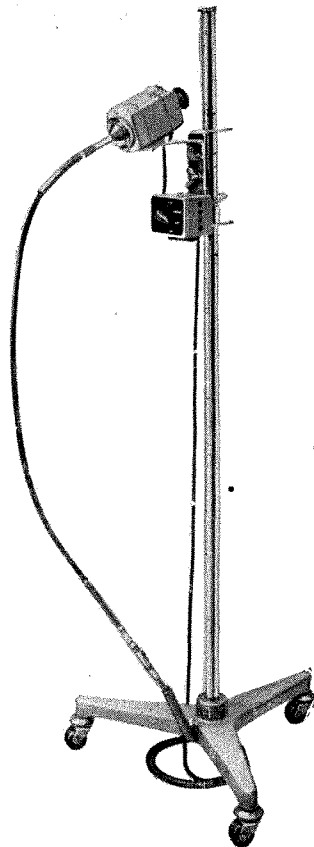
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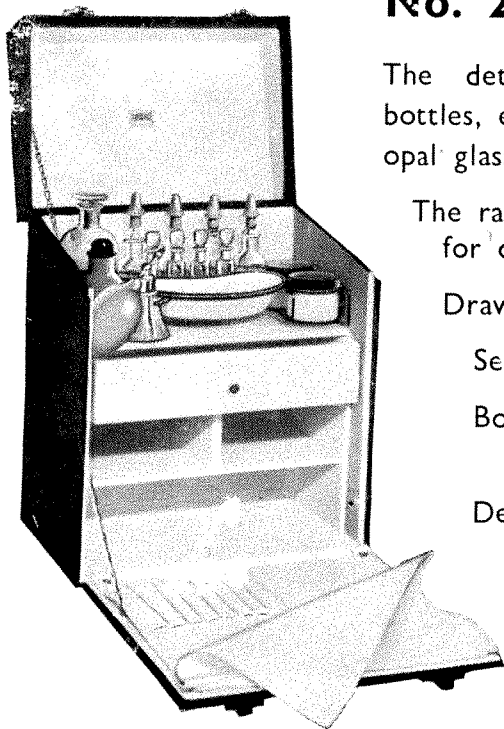
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HON. EDITOR: F. A. DREW, F.Ch.S., M.N.A.Ch.(U.S.A.) Vol. 19. No. 1. January, 1954

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JANUARY, 1954 The position of chiropody in this country has changed but little; we have not marched forward during the past twelve months but have drifted along with the unseeing eyes of the sleep-walker. However, it is refreshing at the commencement of this new year to note that the Society has one eyelid fluttering into wakefulness, and apparently disappointed at finding themselves where they are, for on reading the Editorial of the current issue of *The Chiropodist* one cannot fail to perceive the note of alarm running through it. It is evident that the M.O.H. draft regulations are not expected to fit in with the ideas of the Society. Their belated expression of fear that some Minister of Health might be capable of instituting short courses of training to create the supply of chiropodists employable under the N.H.S. indicates that the M.O.H. probably views chiropody as being on a plane such that a three-years' course of training is unnecessary.

The editorial states that the important question is whether in the end the standards—whatever they may be—will be dictated by the Government of the day, and goes on to observe that they would in such an event have little control over their destiny, for regulations, once approved, had the force of law.

Had the proposed regulations recognised the Society standard as the qualifying yardstick we doubt if any protest would have been heard from that body, but we know what the Minister would have had to face from other quarters. The fact is surely that the Society has played right into the Minister's hand by refusing to co-operate with other chiropodial bodies and thus making it plain for all to see that chiropody is not a corporate body but a collection of conflicting groups, none of which has any authority to speak for any of the others. The Society is unfortunately in the position of a leader who will not lead and therefore has none to follow it, and this is due to its own policy which, like the old Incorporated Society, refuses to believe that it has no monopoly of the profession of chiropody. They evidently still pin their faith on the Cope Committee's recommendations and hope these may still influence the M.O.H.

The profession of chiropody should not be viewed through the restricted terms of those employable under the N.H.S. Indeed, to-day it is more than ever necessary to take a global view and to realise that the policy of splendid isolation adopted by the Society, together with its subservience to the B.R.M.A. constitute the factors which have made possible the

mass invasion of the profession by the opportunists which the M.O.H. may now have to consider as members of the profession. We would point out once more that chiropody should act, not as if N.H.S. employees were the great body of the profession, but realistically in the factual knowledge that the preponderant bulk of its members are in private practice undertaking greater work and shouldering greater responsibility in relation to the public than the small minority of controlled hospital employees. This means that chiropodists should get rid of the B.R.M.A. complex and start national foundations for a united profession and a demand for the legal protection of its members without the delay which permits unhealthy and standard-lowering invasions. Also, we would say once more that the Society should accept the offer of the J.C.C. for a joint consultative committee to examine all the complex difficulties which are of common concern to all members of the profession. It is futile to talk of the hopeful future of the profession without such an effort is made, for without it the invading standard-abasing octopus will drag the head beneath the surface of the engulfing waters.

BACK TO 1949 Referring to the strained relations between the Society and the J.C.C. we observed in our Editorial of February, 1949:

Neither can exert undisputed control over the profession without the other, and neither can speak in the name of the profession as a whole; again, without the co-operation of the other, neither could effectively resist unreasonable conditions which any Government might seek to impose upon the profession.

Also, we think it an appropriate moment to refer our readers to our issue of March, 1949, when chiropody was at boiling point in the hope of its ultimate inclusion under N.H.S. benefits, and to refer them to the

twelve conclusions embodied in the Editorial of that issue. For the benefit of our more recent subscribers we reprint them hereunder and urge them now, as then, to "Ponder these things."

Chiropodists would do well to ponder these things and seek to interpret the writing on the wall. I can but offer you my personal conclusions.

1. *That the Minister is probably hoping that the rush on the services which were so freely promised may in a short time subside, but in the meantime economy forces itself upon him.*

2. *That no Minister is likely, in such financial conditions, to embark on a nation-wide, free-for-all, chiropodial service, for which he would have to budget for many millions of pounds. This is easily seen if one assumes that three-fifths of the population would require some sort of chiropodial attention. Apart from financial considerations the number of chiropodists is inadequate to the task.*

3. *That the inclusion of such a full service under the National Health Service will never be accomplished.*

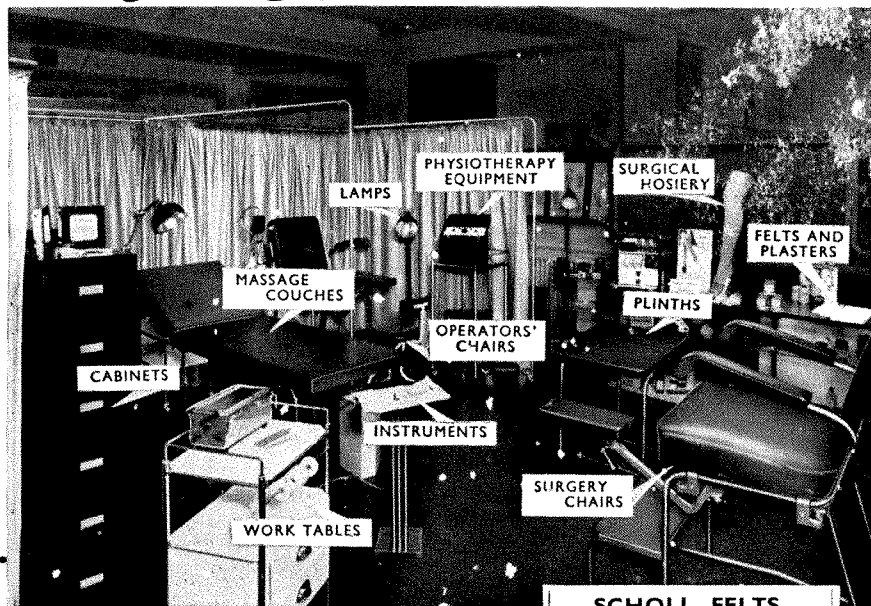
4. *That the service of chiropodists under the N.H.S. will probably be limited to their employment in hospitals, health centres (if and when these eventually materialise), Government works, institutions for the aged, and possibly some patients may be sent to private practitioners under doctor's certificate. Municipal clinics might be taken over by the Ministry, or closed in places where health centres are eventually established.*

5. *That where chiropodists are employed under the N.H.S. their scope of treatment may be very limited. Diagnosis of conditions other than corns, nails, etc. will probably be the responsibility of a doctor, and no doubt all heat treatments will be referred to the physiotherapy department.*

6. *That this will tend to cheapen chiropody*

(Continued on page 8)

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and stultify its growth as a profession, especially if one considers that the training schools may all eventually be in the hands of the Government who will be in a position to call the tune they wish us to play. If they should want a nation-wide service at any time and the number of chiropodists available is found to be insufficient, they could easily order a series of short courses of nail and corn cutting as was done during the war. Should the schools refuse to do this, then as employees they could be sacked and replaced by others. The present disunity of the profession makes us vulnerable.

7. That the private practitioner, responsible to his patients, guided by his conscience, in free association with his fellow practitioners, is in the best position to uphold the dignity of the profession in the public eye and to obtain that great body of public opinion in our favour should the necessity for defence ever arise.

8. That the rank and file of chiropodists should observe keenly the development of political influences which may have even a remote influence on their future

and should bring them into discussion.

9. That chiropodists should not regard a place under the National Health Service as something which is certain to fulfil the profession's aspirations. As indicated in a past Editorial in this journal we may desire state registration but not state relegation.

10. That those in whose hands lies the destiny of our profession will have many knotty problems to solve in the future, and grave responsibilities rest upon them. They will need all the strength of the support which the ordinary members can give, and from what one can hear the ordinary members would be glad to learn more about whatever is happening from month to month.

11. That a statement of policy and aims in relation to the N.H.S. would be welcome to members of all organised bodies of chiropodists.

12. That there should be no further splitting in our ranks, but rather an immediate stage towards unity and strength. How else shall the profession be in a position to meet future dangers?

ERYTHEMA

by Austin Furniss, L.R.C.S., L.D.S., D.P.H.

THE term erythema means nothing more than superficial redness, disappearing on pressure; that is to say, a local congestion of the skin. There is a superficial inflammatory affection of the skin in which redness is the most obvious feature. Erythema, as a substantive disease, shows itself under various forms, all of which may, however, be grouped under two heads, viz., (a) hyperaemic and (b) inflammatory. In the former group the mechanism of the process consists in localised vascular disturbance, which gives rise to hyperaemia—at first active, but if the cause persists, soon becoming passive

owing to vasomotor paralysis. The colour of the affected region of skin which at the beginning is bright scarlet, changes as the blood-stream becomes more sluggish to dull red, eventually to bluish or purple as the tendency to stagnation increases. At the beginning the skin is hot, but as the congestion assumes a passive character, subsides. In erythema of the inflammatory type retardation of the blood-stream goes on to stasis, exudation of serum takes place, leucocytes escape into the tissues around the vessels, and sometimes subcutaneous haemorrhage take place. It is in this way that the various lesions—vesicles,

blebs, oedema, and pigmentation—seen, for example, in erythema multiforme, are produced.

AETIOLOGY Individual predisposition is a necessary condition of the development of erythema. This predisposition appears to be simply an exceptional instability of the vasomotor system, rendering it unduly susceptible to irritation. All kinds of irritation may produce it, e.g., the action of heat or cold, certain vegetable or chemical substances, certain discharges, the bites or stings of fleas, grats, caterpillars; flannel or dirty underclothing, drugs, food poisoning, enemata, and general infections. The irritation in all these cases is direct. The irritation may also be of an indirect type, such as reflected to the nerves of the skin from internal organs, more particularly the organs of digestion. It may also be the result of intestinal toxæmia. It is sometimes a manifestation of rheumatism.

Hyperæmic Erythema Some varieties of this type will be briefly described.

Erythema Simplex This is characterised by a hyperæmic area of pink or scarlet colour, which varies much in size, is not raised, and has ill-defined margins. The chief symptom is a burning rather than an itching sensation in the region affected, and constitutional disturbance is slight or absent.

The latter fact serves to distinguish it from erysipelas. Slight desquamation often accompanies the subsidence of the eruption. From urticaria, erythema simplex is differentiated by the absence of the characteristic weals and by the comparatively persistent nature of the eruption. Simple erythema may occur from a variety of causes. It may result from exposure to the sun (*E. solare*, or *sunburn*), the fire (*E. ab igne*), cold (*E. pernio*, or *chilblain*), or from the local action of irritants as previously mentioned.

CHILBLAINS The lesions of chil-

blains are the round erythematous spots found for the most part on the backs of the fingers and toes, and on the inner border of the hand. They are tender to the touch and itching is a prominent symptom. As the lesions subside, desquamation occurs, but in some cases ulceration takes place. The condition is a result of a local disturbance of the circulation, contraction of arterioles under the influence of cold being followed by dilation as a result of vasomotor paralysis, and later by the other phenomena of inflammation.

Treatment The affected parts should be kept warm and the circulation stimulated by walking exercise, if the patient is not too crippled by the chilblains. Ichthyol ointment or Iodex ointment are useful applications, and may be applied after soaking the affected part in warm peroxide baths. Good results are also obtained by means of general and local ultra-violet light. Injections of calcium and vitamin D are also helpful. Sympathectomy has been advised in very severe cases. With regard to exercises, Lacquet, a French dermatologist, prescribes a special form of procedure which he terms bio-kinetic. This consists in massaging, morning and evening, the fingers and toes in a way which is best described by likening it to the action of forcing a glove on to the finger, while several times a day the joints of the hands are exercised against resistance and the patients should also "mark time" with their feet. This method of treatment is simple, and is said to give good results, but it needs time and determination on the part of the patient to carry it through. Vitamin K has recently been reported on successfully.

Erythema fugax is simply a more transient form of erythema simplex. Patches of redness come out suddenly on the face and body, and disappear in a day or two. In children the eruption is generally the result of reflex irritation, as from disorder of the intestinal tract, from unsuitable

food, or worms. The redness may be either diffuse or scattered over the body in irregular patches of varying size. *Livedo reticularis* is a mottling or marbling of the skin, the affected areas presenting a network of rings of bluish-red colouration. It is often met with in children and young adults as a normal condition, and is exaggerated on exposure to cold (*livedo a frigore*). The condition is of no great pathological importance, but as Adamson pointed out, it is of interest as furnishing a graphic representation of the blood supply of the skin.

Inflammatory Erythema Some varieties of this type will be described: Pernio (chilblains) has been described and Raynaud's Disease, angio-neurotic oedema will now be described.

RAYNAUD'S DISEASE This disease is much less frequently seen in early life. It represents a further stage of the chilblain condition; there is, however, one great difference, namely, the paroxysmal nature of the attack. The cause is unknown. The clinical features and the course of the condition are identical with those of later life. The aim of treatment is to overcome the spasm which is present in the arterioles. The application of a tourniquet for a few moments, followed by a sudden release of the constriction, often floods the ischaemic part and aborts the attack. The remedies mentioned for chilblains may be tried. The condition tends to improve as the child gets older. There is now a medicinal agent which, like surgery, blocks transmission of nerve impulses through the ganglia of both the sympathetic and parasympathetic divisions of the autonomic nervous system. Etamon (tetraethylammonium chloride)—Parke, Davis & Co. is a quaternary ammonium compound. The interruption of the normal transmission of motor impulses in the involuntary nervous system achieved by Etamon aids in relieving nerve-induced constriction of the peripheral blood vessels;

this usually results in an increase in blood supply to the affected extremity as measured by changes in skin temperature or by plethysmograph. Recently benzy-limidazoline ("priscof") has been shown to benefit many patients with Raynaud's disease. It should be prescribed in doses of 25 mg., four times daily by mouth. Side-effects of this drug, especially palpitations, flushing and giddiness, may be troublesome. Local acetyl- β -methylcholine ionisation is helpful in some patients. This preparation is manufactured by Savory & Moore Ltd., under the name of "Amechol."

ANGIO-NEUROTIC OEDEMA All the classical features of this condition are met with in the child. The underlying cause is a vasal paralysis, which permits the fluid elements of the blood to escape into the surrounding tissues. Attacks of local oedema, occurring after the ingestion of certain foods, is the common history. The condition is, essentially, an allergic one, and is allied to urticaria and Henoch's purpura. The patients are, as a rule, highly strung nervous children, and more than one member of the family may show the defect. Treatment includes attempts to find the offending protein, and in this respect protein sensitisation tests may be of value. During the attack, adrenalin, 1 in 1,000 solution, may be tried as a spray or injection (Mii), but if the glottis is the site of the oedema, tracheotomy may be necessary. The diet should be generous in carbohydrates and fats. Anti-histamic drugs such as Thephoran, Antistin, Anthisan and Benadryl are satisfactory preparations. The latter preparation is dealt with in detail under urticaria.

Erythema Intertrigo This is caused by the rubbing together of two surfaces of skin, especially when moist from excessive sweating. It may persist as a simple erythema, but very commonly there is excoriation with much serous discharge, and a true eczema may thus be set up.

Intertrigo is distinguished from eczema by the absence of "weeping." The elimination of the exanthemata is often only solved by the subsequent course of the rash; in all cases Koplik's spots should be looked for and the Schultz-Charlton reaction should be tried if the rash is scarlet in form.

Erythema Nodosum This is common in young women and is characterised by the formation of node-like swellings on the legs and feet, less frequently on the forearms, thighs, buttocks and over the scapulae, and in rare cases on the face. The swellings are almost always symmetrical. The areas are oval in shape, up to one or two inches in length, with their long axes parallel to that of the limb and margins which fade gradually into the surrounding skin. The nodes are at first raised and red in colour, but afterwards become flatter and exhibit the colour-changes of bruises. Fresh crops of nodes appear from time to time, and the eruption usually lasts about a month. *Erythema nodosum* is very rare after 20, and girls show a greater proclivity to it as compared with boys in the ratio of about 2 to 1.

Erythema Iris This condition occurs on the backs of the hands and fingers, the wrists, elbows, and insteps; sometimes also on the nape of the neck. A small reddish disc first appears, on which a central vesicle or bulla develops, which becomes depressed as the disc increases in area. On the outside of this a raised white ring develops, surrounded by a pink area. This arrangement of concentric rings is typical of the affection. Severe forms may occur with serious constitutional disturbance, and the mucous membranes of the mouth, tongue or palate may be attacked. There is a tendency to recurrence, which may take place at more or less regular intervals for years. It will be seen that *erythema iris* is a special variety of vesicular or bullous erythema. *Erythema bullosum* is a bullous, and *erythema purpureum* a purpuric form of the disease.

Erythema Multiforme Only a few words will be written about this condition, which is characterised by its variability, and by the fact that papules, nodes, vesicles, and bullae develop on the primary erythema. These lesions are sometimes further complicated by haemorrhages. The initial lesion is generally a small papule of a dusky colour, and leaving a brownish stain on pressure in its later stages. They appear on the backs of the hands and feet, and extensor surfaces of the limbs. The further development varies. It may simply enlarge, or it may extend at the circumference and clear up in the centre, or the rings thus formed may intersect, or give rise to wandering red lines.

DIAGNOSIS *Urticaria* of the papular variety bears some resemblance to *erythema papulatum*, but the latter can usually be identified by the absence of itching, by the longer persistence of the lesions, and by the fact that they leave stains. The subjects of *urticaria*, further, are usually children, and it is chiefly covered parts of the body, and particularly the lower lumbar regions that are attacked. In the papular stage of eczema, as in *urticaria*, the itching is a marked feature.

TREATMENT The treatment primarily depends upon the discovery of the cause and its removal. The local treatment consists in the protection of the inflamed region, and the application of remedies which relieve itching. Dusting powders are useful, also various anti-pruritic lotions. In intertrigo the opposing surfaces should be separated by small pieces of cotton-wool or lint placed above and below the diseased area, or by the use of powder. Inasmuch as in the regions where intertrigo is apt to occur decomposition of the secretions is likely to take place, this has the result of greatly intensifying the irritation. The parts should frequently be washed with a solution of boric acid (gr. x-xv in distilled water), then carefully dried, and finally thickly dusted over with

some protective powder. Erythema multiforme runs a definite course, and is seldom much influenced by treatment. The treatment should be directed to the removal of any known cause. Gastro-intestinal irritation is so frequently present that it is often desired to give a mercurial or saline purge, and intestinal antiseptics such as salol may be of use. In cases associated with rheumatism, sodium salicylate or other anti-rheumatic drugs may be employed with advantage. Febrile and severe cases require rest in bed and a light diet. The

most useful local applications are calamine and lead lotions.

The chief indications in the treatment of erythema nodosum are rest and the neutralisation of the effects of the poison if there be evidence of the presence of rheumatism. Salicylate of soda in doses of gr. x-xv, according to age, should be given three times a day for this purpose. Hot fomentations locally are often agreeable. When the swelling and other local symptoms have subsided an iron tonic is generally indicated.

Amalgamation Before Registration

The following correspondence, published in the Australian Chiropractor, between the Society of Chiropractors, New South Wales, and the Minister of Health, New South Wales, might be useful as a model for the Society of Chiropractors in Great Britain and Her Majesty's Minister of Health. We recommend it to their notice. The Hon. M. O'Sullivan, M.L.A., Minister for Health for N.S.W., SYDNEY, N.S.W. 11th August, 1953. Dear Mr. O'Sullivan,

A meeting was held on the 3rd instant and the following resolution passed unanimously:

"That the Councils of the two organisations should meet together and iron out their differences with a view to merging."

The accompanying proposal was that once agreement had been reached that a merger was desirable: one of the constitutions (both being incorporated under Section 34 of the Companies Act), with a new name, should be used, and a Council formed consisting of six members from each body.

In view of the foregoing, and to avoid further delay, would you advise, when informed as to the amalgamation and

name of the organisation, if this would be sufficient for you to then recommend to Cabinet the Registration of Chiropractors?

Yours sincerely,
Roger A. A. de Bryon-Faes,
PRESIDENT.

SYDNEY,
18th August, 1953.

Dear Mr. de Bryon-Faes,

In reply to your letter of 11th August, I desire to intimate that I will require to be satisfied that your organisation and the Incorporated Institute of Chiropractors have in fact amalgamated, before I would be prepared to make a recommendation to Cabinet that legislation be enacted to provide for the registration of Chiropractors.

The amalgamated body, it is assumed, would need to be incorporated under Section 34 of the Companies Act, and the amalgamation could best be proved by production of Certificate of Incorporation, together with Memorandum and Articles of Association.

Yours sincerely,
M. O'Sullivan,
MINISTER FOR HEALTH.

CLINICAL PHOTOGRAPHY * - Part I

by Gerald William Lundeen, D.S.C.

A VERY important phase of medical photography is seen in the field of dermatology. It is in this particular field, perhaps, that colour photography is the most important. With the advent of colour film, just a decade prior to World War II, there has been a steadily increasing demand for photographs of dermatological lesions in full colour. This article is written with the purpose in mind to review applications of colour photography in dermatology and to suggest some technical procedures and apparatus that is in common usage to-day.

One of the most important uses of colour photography is, of course, in teaching. During routine lectures to students one is not always so fortunate as to have a patient present who has the particular disease being discussed. An adequate file of colour slides can supply unavailable material for the purpose of illustration and, therefore, do away with the problem of obtaining an obliging patient.

In addition to the classroom needs, photographs are required for several other dermatological uses, such as publication, case histories, and medicolegal evidence. Illustrated histories are especially valuable for demonstrating the progress of difficult cases. These photographic records also can be utilised to advantage in everyday practice. Patients are frequently discouraged at slow improvement, and a series of photographs provides evidence of their former condition and their response to treatment. The doctor, too, will often find a series of records much more efficient and helpful than written notes, rough sketches, or memory

in following the course of treatment.

If various schools, clinics and/or individuals should come upon an interesting case and have it photographed, duplicate copies could be made and given to the others; a sort of exchange system. This would promote a closer relation between these groups and further the knowledge of each as well. If the cost of making the duplicate slides were divided equally among the participants the cost would be minimal and well worth the information gained. If such a group could be formed among the chiropodists, with a member chosen from the group to represent it and to keep the organisation alive, it could, in all probability, become affiliated with one of the larger organisations in the medical profession and exchange information and slides on a grand scale. Many dermatologists have such a group with a central agency which registers each colour transparency sent in by a member, thereby making it available to any other member who may desire a copy.

It does not take very long for one to accumulate a good collection of dermatological colour slides. There are numerous interesting cases seen within a short time in a private office, and the possibilities are infinite in a clinic.

There are several general points to consider before going directly into the focusing and exposure. These are the operational aspects which deal with space requirements and locations, and pictorial aspects which involve the type, extent, selection, and arrangement of subjects. To do this properly the necessary equipment must also be carefully thought about.

Large medical schools and hospitals have well established photographic de-

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partments for making dermatologic records.

However, such an advantage is not always available to the practitioner in his private office. Some doctors do have cameras and lighting equipment in their private offices, but they constitute a minority. Even so, it is seldom that they use their equipment anywhere else, either because it is fixed in a certain place, or because it is not handy enough to be moved about. Even equipment that is easily portable is of no use if it is not ready when and where ever the doctor may be. A dermatological case usually will not keep until the next visit, often not even until the next day.

Suggestions to help chiropodists to use their cameras in their offices, on visits to patients, or in clinics are given in the technical sections of this article. Emphasis is placed on setups not requiring expensive and space-consuming equipment, and a technique not requiring a special knowledge of photography.

The value of a clinical photograph can be greatly enhanced if other pictorial facts of the case are recorded. For example, the records may include technique and results of diagnostic procedures and laboratory findings, etc. In dermatological photography, close-up photographs are required to show details of the lesion and general views to "map" the distribution of eruptions.

Another important point is the adequate recording of the medical and photographic information for each picture. It is surprising how easy it is to forget seemingly insignificant data, and often a photograph of an interesting case is valueless because a necessary date is lacking. The same difficulty can come about when making photographs to show progress of a disease or effect of therapy. If adequate photographic data on lighting angles, working distances and exposure, have not been recorded, it may not be possible to make serial records under the

same conditions. Careful workmanship is a prerequisite to consistently successful pictures.

It should be noted, however, that the use of exactly similar conditions is not always the rule. For example, the lesion itself may be the main subject of the "before" record; however, the same viewpoint adapted for the "after" photograph would be rather meaningless, since the lesion has disappeared and the affected portion alone would be scarcely enough to show the full value of the treatment.

The type of equipment selected depends first of all on the type of records desired. All methods and cameras described herein can be employed for black and whites as well as colour photographs. However, in dermatology, colour photographs are preferred by far. Colour is often the most characteristic feature of a skin lesion and may be of great help as a guide in diagnosing, or as a criterion of progress or relapse.

If a view camera that accepts sheet film is available, black and white as well as colour photographs should be made. This is desirable because black and white photographs are often more acceptable for publication. If a choice must be made between black and white and colour films, colour should be the choice. One can always make a black and white negative from a Kodachrome transparency, although prints thereby obtained do not usually have the quality of an original black and white record.

The doctor working in his office or clinic has a source of electric power and hence can use standlights. On outside visits, however, he will need a compact portable lighting unit to carry with his camera. Then the use of photo-flash lamps or electronic speed lights is indicated since dry batteries will be the only practical source of electricity.

(To be concluded)

SECRET FILES

by G. Stanley Mercer

AND so to 1954. Will it be a momentous year for the chiropodial profession? According to some writers it may well be. Amongst high ranking chiropodists there seems to be some considerable concern that the enforcement of ministerial control and regulations embracing all branches of medical auxiliary service is a distinct likelihood. Having had some experience of slow-moving Government machinery I would not like to predict that any form of official control will be operating before the closure of this year. Nevertheless, it appears clearly on the horizon.

We all know that during the past two or three years the Ministry of Health has been interested in the practice of medical auxiliary healing, particularly chiropody.

We know too that the Ministry has been collecting data and by now must have completed a clear picture of the situation and all the surrounding circumstances.

I should dearly like the privilege of a peep at the relative records. But I will be bold enough to hazard a guess at much of what is contained in those tell-tale files. Can there be the slightest doubt that, in red ink, perhaps, there is an entry implying that the chiropodial profession is split from top to bottom and possesses no negotiating authority properly representative of the profession, and in consequence quite incapable of helping very much in its own internal problems? Neither can there be the slightest doubt that the Ministry's records reveal the important fact that almost two thirds of those engaged in the practice of chiropody do not wear the registered medical auxiliary label. It will also be known to them that

whilst many non-medical auxiliaries blatantly commercialise with a disregard for ethics, a vast number practice efficiently and impose upon themselves the observance of a strict ethical code.

We know of course that the Ministry is well versed in all aspects of chiropodial training. But we cannot be certain about the official attitude to a three-year's course. But it will be known to the Ministry that this somewhat lengthy training period has had the effect of slowing up new entrants which would retard the development of a full chiropodial service for National Health Service purposes.

The official records will no doubt include every essential detail of the local chiropodial licensing (wretched word) system operating in most parts of the country. The Ministry will know that for the most part licences are granted only to those applicants who prove themselves generally desirable.

Armed with all this information the authorities have a good deal to work upon. As I see it, the greatest difficulty is to dovetail one set of regulations covering the varying circumstances surrounding all branches of medical auxiliary service. For example, the practice of chiropody is the only section registered with the B.R.M.A. which can be practised without medical direction. This in itself will give rise to difficult complications when overall regulations are named.

And if ministerial control does come, what is the most likely form it will take? It may confine itself to the Health Service only, leaving chiropodists free of control where private practice is concerned. Or it might go the whole distance and

bring about the closure of all medical auxiliary service in its entirety by means of state registration.

Personally, I rather expect the former less drastic course to begin with, gradually leading up to complete closure.

But whatever course is followed, it will be a sorry day for the professions concerned if it is left to the Ministry to impose controlling regulations without the proper guidance of the respective professions.

We must not close our eyes to this serious danger. But if that does happen can we honestly blame the Ministry? Indeed, what other course can it take? So far as chiropody is concerned there is not in existence a negotiating body properly representative of the profession as a whole. It is there that the profession's greatest evil lies. It has been obvious to the most casual observer that the Ministry concerned is unwilling to be guided by those representing sectional interests. The rejection of the Cope Report made that abundantly clear.

I seem to sense that those responsible for the direction of an isolationist policy have become worried men and women. They fear Ministerial intentions. Let them face up to the inevitable. A continuance of their wretched isolationist policy is doomed to utter and complete failure. The only course open to them is sensible negotiation between the two opposing chiropodial forces followed by joint consultation with the Ministry.

Those entrusted with the direction of this journal's policy have persistently warned of the dangerous waters the profession is drifting into. As time passes so the danger becomes more and more manifest. I have been told that even if the two major organisations came together and ironed out their difficulties tomorrow, it would be too late. Well that theory may be right, but those of us who have devoted so many years in an endeavour to unite the profession, must go on and on until the last chapter has been written.

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OFFICIAL PRONOUNCEMENT SOON?

I HAVE IT on reliable information that the Ministry of Health is nearing the end of its examination of all the circumstances involving medical auxiliary practice, and a pronouncement as to its intentions in the matter of control may be expected soon.

There need be no undue panic amongst chiropodists. Whatever the controlling regulations turn out to be I feel quite certain that they will not be any more injurious to one practitioner than to another.

I would not like to suggest that the regulations will be entirely palatable to all. Indeed, they may not please very many. But in the circumstances of the chaos prevailing within the profession that must be expected.

HELPING THE AGED

THE PROFESSION is to be congratulated upon the splendid way it is rallying to the noble service of the aged and infirm.

The local press in all parts of the country are reporting facilities being established for their free treatment. The various organisations making this possible are also deserving of the highest praise.

ARRIVED FROM THE CONTINENT

THE CONTINENT is certainly recovering from the effects of war devastation. Its

factories are in full production as evidenced by a remarkable range of chiropodial appliances and requisites I have just seen.

I still think that the British manufacturers are in the lead, but they must certainly look to their laurels. Prices are rather high, however, because of the heavy duties.

ANOTHER POSSIBLE JOINT EVENT

AT THIS EARLY STAGE it would be indiscreet to state names, but I understand that another social event, to be staged jointly by branches of the Society and Joint Council, is under consideration. I earnestly hope the proposal materialises. We want many more of these happy social events.

IS IT DESPERATION?

IT MAY BE just coincidence, but I am receiving an increasing number of reports about chiropodists indulging in quiet advertising. Many of them are under an obligation not to do so. Are they driven to it in desperation? That will probably be the explanation if found out.

NOT LOST TO THE PROFESSION

IN THE COURSE of a further chat with Mr. N. Tertis, the former general secretary of the Joint Council of Chiropodists, I was glad to hear from him that he does not intend to retire completely from the field of chiropolitics. He will be happy to give the profession the benefit of his advice and wide experience when invited.

That is a very nice gesture, as only too often high officials are lost to the cause when they retire from office.

I have no information as to the identity of Mr. Tertis' successor.

THE BUSINESS BAROMETER

FOR THE TIME of the year most practices are doing remarkably well. They have, of course, been favoured with mild weather conditions. But the testing time has arrived with colder conditions and as I write places on the Sussex-Hampshire border are ice-bound, which has produced a number of cancellations.

GOOD PUBLICITY

A PROMINENT MEMBER of the Society is responsible for some good professional publicity. It clearly reveals the value of not only chiropodial treatment, but the training as well. There is a certain

controversial aspect of the publicity which has been questioned—rightly so in my opinion—but its general theme is the kind of nation-wide publicity I applaud. Anything of this nature ethically conducted is of tremendous value to the public and profession alike. Much more of it, please.

TWO LOCUMS WANTED

A LOCUM is required for a West Coast town for the month of July. Another is wanted for a South-West Coast town for September and early October.

As usual I shall be inundated with applications, which will be passed on to those concerned and for me that is where it will end.

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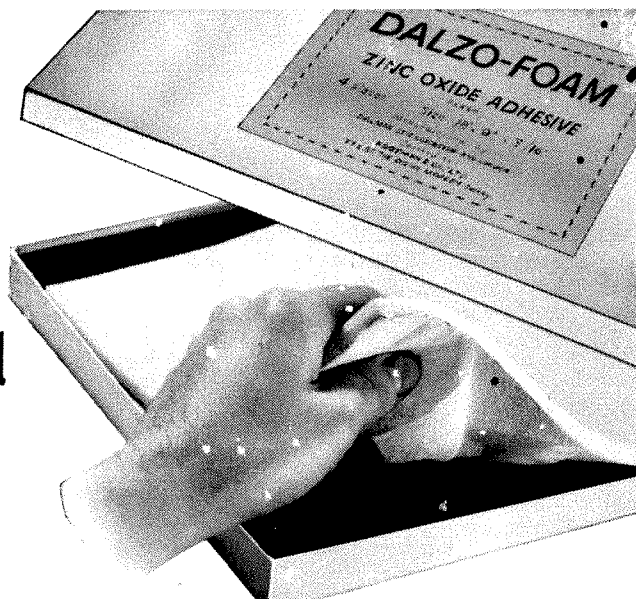
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Pain occurring only at night may suggest neuritis. The important question in a given lesion is whether the primary cause is infection in a foot with good blood supply, or whether the cause is primarily deficient blood supply. Examination of the legs may yield the following evidence of deficient circulation; (a) reddish areas, discrete and never numerous on the legs and feet, later replaced by pigmented areas or scars; (b) blisters or blebs, developing especially on the toes without known trauma; (c) cadaveric pallor of the toes on elevation and (d) redness or cyanosis of the foot when hanging down; (e) shiny red, slightly swollen toes; (f) atrophy of calf muscles on one side or a trophy of subcutaneous tissue or of the nail bed with short, thick nails. The clinical examination may reveal (1) absence of pulsation in femoral, popliteal, posterior tibial or dorsalis pedis arteries; (2) with legs bared, the hand will detect a change in skin temperature when passed downward from the thigh. A gradual change is normal but a definite level of change suggests deficient blood supply; (3) the oscillometer gives quantitative evidence of the level at which large vessels are occluded, but for an estimation of the more important collateral circulation other tests must be utilized.

The prophylactic treatment for the prevention of gangrene is important and to-day chiropodists in hospitals, institution

and private practice are doing much to lessen the incidence of diabetic gangrene and its dire results. Typical gangrene is preventable. Injury and infection can be avoided. It is our job to teach patients what they themselves must do to avoid this condition.

British Journal of Physiotherapy

THE FOLLOWING is a summary of an interesting abbreviated history of Michael Faraday, appearing in the above journal:

Michael Faraday, chemist and physicist, son of a poor blacksmith, born at Elephant and Castle, London, in 1791. Bookseller's messenger boy at 13, book-binder's apprentice at 14—without fee—which gave him the opportunity of reading books from which he discovered his interest in science, and especially electricity. At 21 he attended lectures by Sir Humphrey Davy, of whom he asked help in his studies. At 22 laboratory assistant at the Royal Institution at 25s. per week. He made experiments and at 32 became a Fellow of the Royal Society. At 34 he was appointed Director of the Royal Institution and discovered the principle of electromagnetic induction, and the conversion of magnetic energy into electrical energy. He coined the words electrolyte, electrode, electrolysis, ion, anode and cathode.

At 47 had a nervous breakdown and was ill for five years. At 60 his health was again failing but he continued to study the relationship between electricity, light and gravitation, the solution to which problem Einstein was to supply in 1915. At 66 he refused the Presidency of the Royal Society and at 67 Queen Victoria presented him with a home at Hampton Court, at which house he died in 1867. He was buried on Highgate Hill in silence, according to his own wish, and his tombstone was inscribed simply Michael Faraday.

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LETTERS

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal

FLAT HEELS

SIR,—In reply to Mr. A. Wardle's letter in the December issue of the *B.C.J.*, I would first point out that my paper was not primarily a criticism of Mr. Wardle's paper. The text was, as stated, merely provoked by a statement made by him.

Mr. Wardle complains that I have taken a short passage out of its context, but it is obviously not practicable to quote the whole of the paper, nor even a substantial section of it. If a reader is interested the original article is always available for reference—that is axiomatic. However, Mr. Wardle implies that by isolating a small part of his paper I have in some way distorted the import of his writing; this I refute emphatically. The section which I quoted, contained a categorical assertion that he believed it erroneous to attribute many foot disabilities to the wearing of high-heeled shoes and also that within the normal range of feet high-heeled shoes may be permissible and harmless. The passages which followed these statements may have illustrated Mr. Wardle's principles in deciding how he considers heel height should be assessed, but they do not alter the fundamental points in the slightest degree.

Mr. Wardle assumes some amazement at my commendation of the flat heel, but there is nothing novel or extraordinary in that concept. It is surely generally recognised that pedal function is at its best when the component forces are balanced and complementary. This is not a revolutionary idea, neither is it an original one. The raised heel has been authoritatively condemned many times and the flat heel considered ideal. The fundamental point

is surely quite clear; when the heel is elevated the function of the normal foot is imbalanced, while the less raised it is the more balanced will be its function, and structural and functional imbalance lead to disorder.

Mr. Wardle finds curious support for his arguments by mentioning that my views would receive little respect from commercial circles. More's the pity, but it will be a regrettable day when we allow commercial interests to decide the ideals of human well-being. In any case, it is somewhat difficult to understand why Mr. Wardle believes that the idea of flat-heeled footwear would receive little respect commercially for, as is well-known, flat-heeled shoes are made in no small numbers. In fact, as I write, I have before me a catalogue of ladies' shoes by a well-known firm and in it there are almost as many flat-heeled as there are raised-heel shoes.

Finally, I would re-assert my belief in the harmful effect of the raised heel and I maintain that a plausible case to support the desirability of the raised heel in footwear for normal feet has not yet been made.

W. D. WATTS, M.Ch.S.

St. Albans.

FUTURE PROSPECTS

SIR,—In company with many persons of far greater distinction than myself, I have just concluded an independent inquiry into the true surroundings associated with chiropody. Unfortunately this inquiry has been personal and in no way collective, so the opinion I express is entirely my own.

First and foremost we have, in the palm of our hand, opportunities for a very great future. All sections of the chiropodial world are now in a position of equal advantage; let us therefore in 1954 be utterly ruthless in removing the cob-webs which have restricted our mental vision in the past.

T. HAROLD DARLINGTON, M.Ch.S.

Swansea.

CASE NOTES

PAINFUL LESION

THE following is in the nature of a story rather than detailed Case Notes, but may have an interest. About 21 months ago a young French lady came to me with a very painful foot. Whilst in France she had contracted a lesion under the metatarsal heads which had been diagnosed as verruca and treated primarily by luna caustic, then by X-rays, and finally by excision. Far from disposing of the trouble, the foot became more painful. On coming to England she visited other chiropodists and still the lesion remained very evident and very painful.

To me there seemed several possibilities—

1. That the original lesion might have been a vascular callous and/or corn, mistaken for a verruca, and that this persisted coupled with scar tissue.
2. That the lesion was a modified and vascularised resuscitated verruca plus scar tissue from excision.
3. That the lesion was a vascular result of the multiform treatment of a verruca no longer present, coupled with scar tissue from the excision.

In either of these cases there was little doubt that weight-bearing was aggravating the matter and occasioning great pain.

I proceeded therefore with mild escharotics to remove all the discoloured tissue and scar tissue and provided suitable padding to relieve weight-bearing, and after a number of visits had reduced the whole to a clear area with only one tiny reddish speck in it, which I concluded was a damaged capillary, when she announced her return to France. By this time the foot was painless, the patient walking normally and very pleased to have relief. I therefore made her a removable rubber pad for protection and weight-supporting and gave her a letter to her home chiropo-

dist in which my treatment was detailed for his information, for which he conveyed thanks.

From that point, now some 18 months past, I heard nothing until this week I received a letter from the patient telling me that on arrival in France her chiropodist had reverted to his treatment by AgNo 3, but instead of improving further the foot had become very painful so she had given him up and gone to a "healer," who had treated her by manual contact only with emanation of so called "magnetic rays," but again with no results. She therefore decided to try home treatment and by means of clean scissors she removed some hard skin, but made the foot so painful that she decided that was useless too, so she decided then merely to bathe it, keep it scrupulously clean and allow it to calm down once more. This proved very successful and the troublesome spot became less and less painful and is now clearing so well that she can walk without the pad in a normal way.

By the rules of etiquette I was correct in referring this patient back to her former chiropodist, but I cannot help wondering whether it would not have been more to the patient's interest to have told her to wear the pad, keep the site clean, and nature would gradually do the rest? And yet, I still think that scar tissue may again prove troublesome, so I am writing her, suggesting that she continue as at present, but that she also applies dressings of Vitamin E cream.

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NOTES AND NEWS

Schemes for the Aged

NEWPORT ROTARIANS heard Mr. J. Murray Wickham, of Newport, Isle of Wight, stress the urgent need for free chiropody for old people, in the course of his talk at a recent luncheon. Dr. Wallace, county medical officer, thanking the speaker, said that although the welfare authority had power to extend free treatment to all old people in the island, the step had not been taken lest rates should be increased. He hoped that something might be done through the recently organised old people's welfare association.

MOBILE CHIROPODY UNITS, provided by the Liverpool Queen Victoria District Nursing Association, are envisaged by Prof. A. B. Semple, the city's medical officer of health.

A QUARTER of the 2,000 old age pensioners in Ashford, Kent, are too frail or infirm to walk out of doors, according to Mr. J. Fagg, chairman of Ashford Old People's Welfare Committee.

A chiropody scheme, in which local chiropodists have worked for a reduced fee, is proving a great success as a means of improving this situation.

CAMBERWELL, London, Red Cross, report that old people have to put their names on a waiting list for two months if they wish to have chiropodial treatment under their scheme. This gives an indication of the demand for the chiropodist service.

FEET WERE DESCRIBED as "one of the most difficult parts of the anatomy of old people," by Mr. James Johnson, M.P., when he spoke recently to the Over

Sixty Club at Rokeby, near Rugby. He said that he would like to see chiropody in the National Health Service.

A CHIROPODY SCHEME for old people in Stanley urban area, Newcastle, is now being considered.

THE NEED for a chiropody service for old people in the area, a need outside the National Health Service, was stressed by Dr. A. Donaldson, Medical Officer of Health for Bedlington, Newcastle, in his recent annual report.

He also drew attention to the considerable difficulty of obtaining funds to pay for the professional services of a chiropodist.

CONISBROUGH, YORKS., Urban Council are to allow free use of a room at Castle Farm, Conisbrough, on Friday afternoons for a chiropodist service for old people, arranged by the Old People's Welfare Committee.

A FORTNIGHTLY chiropody service was instituted by the Ottershaw Old Folk's Club in the local Red Cross Hut recently. A charge of 1s. will be made for treatment.

CHIROPODY TREATMENT for old age pensioners has recently been introduced into a Braintree, Essex, over-sixties club.

OLD PEOPLE who make use of the chiropody service at the Scunthorpe, Lincs., St. John Ambulance Brigade building in the High Street, will not now have to pay 1s. for treatment.

Scunthorpe Old People's Welfare Committee decided to rescind a previous resolu-

tion, but agreed that a box should be placed in the treatment room for voluntary contributions.

PROFITS FROM A BAZAAR, held by Mansfield, Notts., Old People's Welfare Committee, recently, will be used to start a "cheap chiropody" scheme for old folk. All goods on sale were made by members of old people's clubs in the area.

A "FOOT COMFORT" scheme for pensioners was recently started in Retford, Notts. by the local Old People's Welfare Service. It enables pensioners who cannot afford full chiropodist's fees to have expert treatment for a few pence.

New Flexible Insole

WELT FLEXIBILITY, achieved, particularly in women's footwear, through the use of lightweight and flexible innersoles and outsoles, presents more of a problem to the maker of heavier men's footwear, and it is the subject of a new development in insole processing in the United States. A series of tests on the new insole was conducted by the U.S. National Foot Health Council, which is to grant its seal of approval to shoes made by this process.

Teaching the Parents

MINOR DEFORMITIES of the feet, due to ill-fitting boots and shoes, are so common among children visiting clinics in Essex

that arrangements have now been made for parents to be shown how to fit footwear.

A member of the Essex County Council health staff recently said that much of the suffering of old people with bad feet could be traced to early neglect. They wanted to make mothers foot conscious.

Corns in the Shipyard

A CHIROPODIST was called in recently to deal with the corns of which shipyard workers at Hartlepool complained to their employers.

Foot Convention

SPEAKERS at the Foot Health Educational Bureau's Convention on March 1, 1954, at the Caxton Hall, Westminster, who will take as their theme "Fitting the Normal Foot," will be Mr. H. E. Walker, F.Ch.S., of the London Foot Hospital, Mr. R. Ledger, of Bective Shoemakers, Northampton, and Mr. J. Carter-Johnson, of Bentalls Ltd., Kingston. Admission is free by ticket only on application to the Foot Health Educational Bureau, Central Council for Health Education, Tavistock House, Tavistock Square, W.C.1. The meeting begins at 6.30 p.m.

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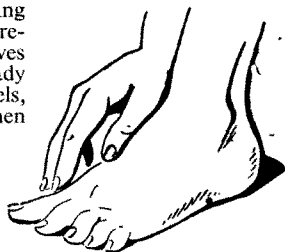
A CHIROPODIST was not, as a Cockney boy was once reputed to have said, "a bloke who teaches canaries to sing," Mr. H. H. Rawlings told Tewkesbury

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Rotarians at their weekly luncheon meeting recently. In the course of his talk he outlined the history of chiropody from the middle ages to the present day.

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ROTHERHAM CHILDREN are generally well shod, according to the recently published report on school health; but parents do not pay enough attention to socks or stockings being of the correct size.

Success of Foot Week

BIRMINGHAM FOOT HEALTH WEEK is felt by its organisers, the Foot Health Educational Bureau and the Birmingham Health and Education Departments, to have been a great success. The exhibition drew good attendances each day, and the various lectures and discussions attracted over 1,200 people. Schools, factories and technical colleges sent special parties. One of the purposes was to discover the attitude of health departments and their staffs

to the subject of foot health education, and the excellent co-operation which the bureau received from the city health and education officials gave a reassuring answer to this question.

Chiropody in Parliament

SEVERAL QUESTIONS have been asked in the House of Commons recently on the possible inclusion of chiropody in the National Health Service; Mr. Harold Davies (Lab., Leek) said that many hospital patients were found to be suffering from foot troubles, and Miss Elaine Burton (Lab., Coventry South) stressed the inability of old age pensioners to afford treatment. Answering another question later, Mr. Iain Macleod, the Minister of Health, said that he would like to provide chiropody for old age pensioners as part of the National Health Service, but the economic circumstances did not permit this.

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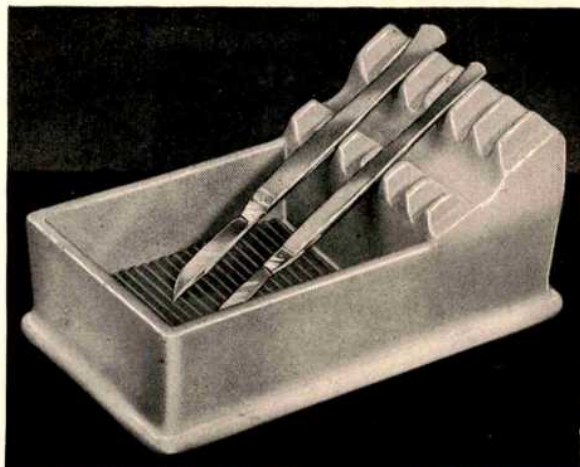
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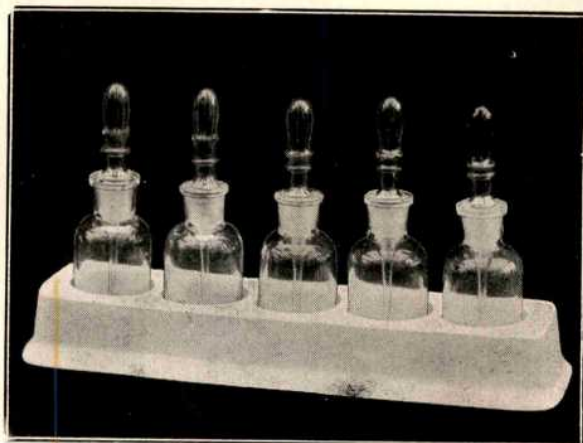
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THE MINISTER HAS SPOKEN The long awaited edict of the Minister of Health announcing his regulations concerning the employment of medical auxiliaries under the National Health Service was officially laid before Parliament on January 19 last, and will operate as from April 1 next. They are set forth in a white paper, headed "Statutory Instruments," 1954, No. 55. National Health Service, England, and copies may be obtained from Her Majesty's Stationery Office, price 3d. Briefly, and avoiding official phraseology, the Minister states that the qualifications required by a person for employment by an "employing authority," i.e., regional hospital board, hospital management committee, board of governors of a teaching hospital or local health authority, are as follows:

(1) That on March 31, 1954, he was already employed by one of the following: Regional hospital board, local health or education authority in Scotland, Northern Ireland hospitals authority, Northern Ireland tuberculosis authority, or a health authority or welfare authority constituted under the Public Health and Local Government Act, (Northern Ireland) 1946, in Northern Ireland.

or (2) That he shall have passed the qualifying examination of either the Joint Council of Chiropodists or the Society

of Chiropodists after attending a full-time day course of training in chiropody for not less than 2 years.

or (3) That he holds a certificate issued by the Joint Council of Chiropodists or the Society of Chiropodists

(a) certifying that he has attended a course of training and passed an examination, approved by the Minister, or

(b) certifying that outside the United Kingdom he has attended a course of training and passed an examination recognised by them and approved by the Minister.

or (4) his name is included in a list kept by the Minister of persons not qualified in accordance with the foregoing conditions, who have satisfied him that their training and experience are adequate for employment.

or (5) his name is included in any list of persons suitable for employment as chiropodists kept by the Secretary of State for Scotland, or the Minister of Health and Local Government for Northern Ireland.

It is evident from these regulations that what the Minister has done is to leave the situation more or less as it has been for a long time and he continues to retain the right to employ anyone whom he considers

fit for the job. What he has done is formally to set forth the principles which guide him in his selection and by giving his qualified blessing to both the Society of Chiropodists and the Joint Council of Chiropodists, he has taken away the right of either of them to disparage the other.

It is not stated whether individuals claiming eligibility under sections 4 and 5 of the above are required to make personal application to the Minister for recognition and inclusion on his lists, or whether this will only be dealt with by application form when a person applies for a job under the employing authority. If the former then the Minister may expect to be inundated with applications, and his resulting lists may well constitute a sort of basis for a National Register of Qualified Chiropodists.

However, it is equally obvious to us that the Minister of Health is far too busy with greater matters to conduct exhaustive inquiries into the qualifications and experience of several thousand individuals, and it is obvious that he will require the assistance and guidance of those bodies named in the regulations. We may therefore expect to hear of further meetings between the Minister and the Society and the J.C.C., with the object of sorting out those eligible among their own memberships and to establish some method of investigation into the claims of others outside those bodies.

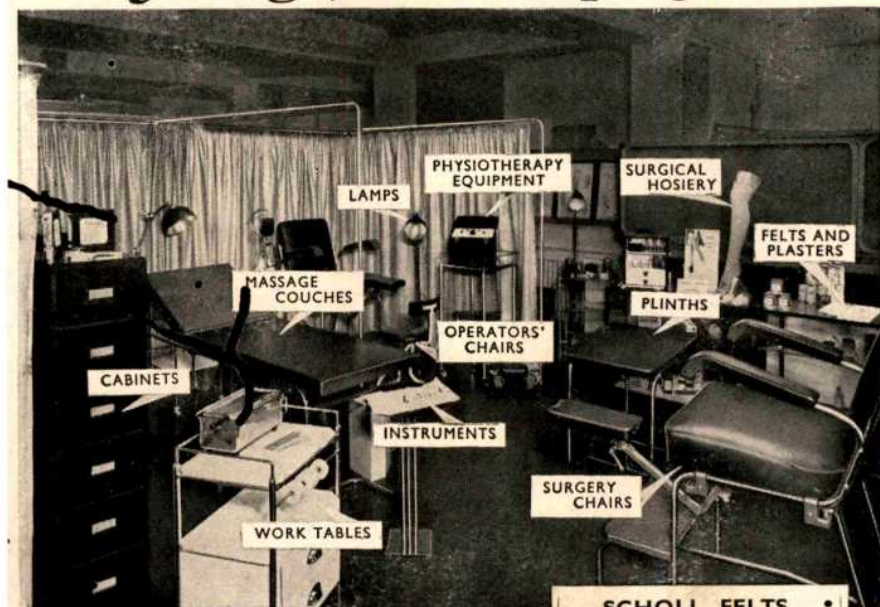
It is evident that the Minister is not satisfied that membership of either body is ipso facto a guarantee of suitability or proof of adequate qualification, and if the Minister has been forced into this position it is the responsibility of the profession itself. The Society refused the invitation of the J.C.C. to form a joint consultative committee, with a view to examining and finding a solution to the common problems with which the profession has been faced for years; they did not see that any useful purpose could be achieved by such a com-

mittee. The effect has been that lack of unity in the profession has obliged the Minister to assume the role of judge as to qualifications, a role which rightly belongs to the profession operating within a framework set by Act of Parliament. The Minister is of course concerned only with the limited need for chiropodists under the National Health Service, but the profession should be vitally and actively concerned with its own state of health; it suffers not merely from a local complaint to be cured by the Minister's regulations regarding his employees, good or necessary as such regulations may be; it suffers from a systemic disease and the whole body needs overhaul, co-ordination, excision of necrotic tissue, healthy environment and its continued existence and development regulated by appropriate legislation. The disease might be labelled Pseudo-professional Opportunism and it is bringing the patient very low.

WHAT THEN? It is evident that the Minister will need to consult both the J.C.C. and the Society, and it is equally evident that no good purpose will be served by these two bodies ignoring each other or working as separate units at variance with each other. The J.C.C. have already ineffectively approached the Society, as previously reported; it would be a good thing if the Society now approached the J.C.C. so that they could co-operate closely to frame a common policy, not just for employment under the N.H.S., but for the future independence and legal status of the whole practice of chiropody in this country.

The Society, as the largest organised body within the profession, has the future of chiropody very largely in its hands, but it is headed into the cul de sac of the B.R.M.A., which seems to offer no outlet for progressive advancement and development as an independent profession aspiring to logical progressive development. Retirement

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ment from the B.R.M.A. would in no way affect the employment regulations of the M.O.H., as can be seen from the fact that he has also made regulations for the employment of physiotherapists, including the Chartered Society of Physiotherapists who long ago resigned from the B.R.M.A., and two other bodies which have never been in the B.R.M.A. The profession needs freedom of action to co-operate with those who, whilst not thinking precisely along the same lines as the Society, do nevertheless honestly desire to create a profession with dignified legal status in the interests of the public and of every chiropodist worthy of the name and to the exclusion of those who are not. It will be a Red-letter day and a sign of reviving health when such co-operation commences, and those who take the initiative will be worthy of the highest praise.

THREE YEARS' COURSE. It is to be noted that no mention is made of a three-years' course in the Minister's regulations. Obviously it would have been futile to impose this as a condition at the present moment for it is only recently that courses of this duration have been instituted and from which no graduates have so far emerged. It is also noteworthy that in the cases of all the other auxiliary medical bodies, dieticians, laboratory technicians, occupational therapists, physiotherapists

(except the Physiotherapists' Association), radiographers, remedial gymnasts and speech therapists, no particular duration of the training period has been imposed.

FAREWELL It with very great regret that we have to record the death of Mr. E. G. V. Runting, F.Ch.S., who died on January 16.

Mr. Runting, who might well have been described as the Grand Old Man of Chiropody was an outstanding figure in the profession in this country, known to all whether members of his society or not. He was perhaps best known for his textbook *Practical Chiropody*, first published in 1925, a work which proved so popular that in 1952 he was called on to publish its 8th edition in revised form. His name was a household word and well known beyond the confines of Britain as a great pioneer who did much spade work in preparing the way for chiropody as it is to-day. He emphasised the need for a combined sound theoretical knowledge and practical skill, acquired by diligent practice, encouraged the learner, but deplored the invasion of the profession by the untrained practitioner. In the latter years of his long life he had necessarily retired to the background, but his keen interest in the profession's welfare was maintained to the last.

Many issues have divided the profession during the lifetime of the G.O.M., but all members of the profession will be solidly united in paying genuine tribute to his memory, and in sorrow at his death. On behalf of this journal and its many readers we extend to his family and relatives our expressions of true sympathy in their great loss in which we feel we bear a part.

Mr. Runting held a unique place not only in the chiropodial profession but also in the hearts of his fellow-chiropodists and one that will be difficult to fill.

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EFOCAINE IN ANKLE SPRAIN TREATMENT

by R. S. Gilbert, B.S., Pod.D.

WE have all encountered at one time or another patients who presented themselves with permanent ankle joint disabilities which might have been avoided by proper early diagnosis and therapy. Ankle sprain is probably the most common orthopaedic injury seen and certainly presents a subject of general interest.

The old folklore that "A sprain is worse than a break, and ligaments do not heal as well as bones" constitutes an axiom that bears investigation. Assuredly so, the above statement results directly from the improper and lack of immediate treatment of the injured ankle. Fractures are treated with the utmost care and precaution resulting in the majority of the time of a good, stable functioning joint. On the other hand, a sprain not properly treated will cause serious disability. One must remember that neglect of what might seem a simple sprain can cause permanent injury.

METHOD Methods of treatment are varied, but the ultimate aim of any therapy should be towards the restoration of normal weight-bearing relationships and relief of pain. When dealing with service personnel another factor enters the picture, that being of early mobilisation and back to duty. There are, however, some forms of therapy that restore the patient to normal activity sooner than others and in the case of the armed forces should be utilised whenever possible.

It is the purpose of this paper to review the treatments of ankle sprain and to present a method which the author has used recently with favourable results.

PROCEDURE All ankle injuries should be X-rayed as soon as possible. Views taken should include the anterior-posterior,

lateral, and in certain instances, the various obliques. A negative radiograph taken immediately after the injury does not necessarily rule out fracture.

Many times additional views will show a small chip or tear that escaped detection the first time. The author has found that with no evidence of fracture, but with the patient presenting a history of severe trauma or twist, discolouration and severe pain, an incomplete or complete tear of one or more of the three lateral ligaments should be suspected. With the patient under anaesthesia (local or general) the injury may be shown as a dislocation of the talus with complete disruption of the external lateral ligament. The foot is forcibly inverted and the subluxation and upset joint space can be clearly shown by roentgenogram. As with fractures, any complete tear of ankle ligaments should be treated by complete immobilisation in a plaster cast. In the vast majority of ankle sprains the ligaments involved are only slightly damaged and may be treated by various methods. It is this type of injury, specifically, that will be discussed.

DEFINITION There have been many definitions given to sprain but for our purpose "a sprain is generally considered to be a rupture or avulsion of a ligament, partial or complete, or with just minute fibres involved". Treatment should be based on the understanding of the natural processes of healing. The progressive increase in tensile strength of an involved muscle, tendon, or ligament must not be interrupted by too early active motion but, at the same time atrophy must be prevented as much as possible.

The basis of treatment lies in the above statement, a happy medium must be reached between motion and immobilisation.

IMMEDIATE TREATMENT The proper immediate treatment will pay dividends as to the ultimate outcome of the patient. I consider four general principles in the immediate treatment of all strains and sprains.

These are:

1. *Cold*—We know that oedema and haematoma form quickly, caused by an excessive amount of lymph in the area, due to slowing down of the circulation following the injury. Cold, in the form of ice packs, will constrict the arteriolar bed and diminish haematoma formation.

2. *Compression*—Aids in checking active bleeding, and disseminates haematomas already formed. Foam or sponge rubber placed over the area of injury under the strapping does a very efficient job.

3. *Support*—This along with early weight-bearing is where the middle course must be steered between motion and immobilisation. An injured part has to have support in one form or another. To inject novocaine into an injured ankle and to let the patient walk out of the treatment room completely free of any support is merely permitting the injured area a chance to further damage.

4. *Relief of Pain*—A sprained ankle is painful, in fact, at times it can be considered as an extremely painful condition. A patient coming in with such an injury wants, above all, relief from pain, in the service, as in civilian life we know that we perform our duties at a greater efficiency when we are pain free. The use of local anaesthesia with supportive strapping affords an excellent means of therapy. Without support, the patient receives a sense of false security at the expense of further injury to the already damaged

ankle joint. Pain may be satisfactorily controlled by the use of salicylates and local anaesthesia. The author will discuss efocaine as a local anaesthesia for the relief of pain in ankle sprain.

TREATMENT 1. Adhesive Strapping—

There are various strappings that can be used with some giving a greater amount of immobilisation than others. I prefer the modified Gibney² which consists of the following: The foot held slightly extended, with no inversion or eversion. I do not believe in over correction, that is to say if the injury were of an inversion nature causing pathology in the area of the lateral ligaments we do not place the foot in any everted attitude at all. The foot is held in a neutral position, thereby having the ligaments supported in their normal manner, with no relaxation of eversion to upset the normal process of healing. Four one-inch wide strips of adhesive tape, about fourteen inches long, are started below the malleolus on the side of the ankle opposite the pathology. It is carried across the plantar and up the opposite side of the leg. These strips are applied with slight tension, with each strip over-lapping the preceding one anteriorly by one half-inch. One-inch strips are now applied, starting on the dorsum of the foot on the same side as the pathology. This strip is either started dorsally behind the head of the first or fifth metatarsal and brought along the side of the foot, around the posterior of the heel, along the other side of the foot to a point behind the head of the first or fifth, as indicated. Enough strips are applied until the medial, posterior and lateral aspects of the ankle are encased with each strip over-lapping the preceding one slightly. An opening of about two inches is left on the anterior of the ankle and on the dorsum of the foot. It is wise to incorporate the use of a stirrup to maintain the desirable position of the

foot while strapping. Proper preparation of the skin prior to strapping is important for the patients' skin hygiene.

2. *Procaine infiltration*—Bakst³, McCormic³, Webber⁴, McLaughlin⁵ and some of our other illustrious military surgeons used this technique to great advantage. They found that in a very high percentage of cases the men injected could return immediately to duty without discomfort. This treatment was extensively reported in the many service journals during the last war, but actually can be reported way back to 1936 when Leiche⁶, the Frenchman, first introduced it. The only objection is that not enough emphasis is placed on the supportive therapy after injection. Especially in the service when you are dealing with active young men, further protection is almost a necessity. Infiltration with proper support is by far the outstanding treatment up to date. However, Hutchinson⁷ believes that procaine block of the sural nerve is superior to the method of local infiltration. His reasons are that pain is less likely, and trauma from the needle puncture in the injured area is avoided.

3. *Ethyl chloride spray*—The use of this technique was very ably discussed and reported by Price⁸. He and his associates used this method extensively in the army with favourable results. The area is sprayed with ethyl chloride until the skin is blanched and firm, massaged and then sprayed again. The ankle is then snugly wrapped with an elastic bandage and the patient returned to duty. We have found that it takes more than one treatment to alleviate pain and this type treatment is more amenable to the slightly sprained ankle where only minute fibres are involved.

4. *Use of efocaine*—Local anaesthesia for relief of pain from ankle sprain has long proved its efficacy. Many methods were proposed to extend the duration of local

anaesthesia, but it was not till the development of efocaine (Fougera) that a safe, non-toxic agent, capable of producing prolonged anaesthesia was produced. Efocaine has been well reported in the literature during the past year. A long lasting local anaesthetic solution has been the goal to control many types of post-operative pain. Puderback and Shafel⁹ reported its use in upper abdominal surgery. Tucker¹⁰ reports of its control of post-operative pain in ano-rectal surgery, and it has been utilised and reported with excellent results after thoracic surgery¹¹. Why not use this preparation for the relief of pain from the very common but extremely painful "sprained ankle?" A sprained ankle patient is just as thankful for the relief as one recovering from hernioplasty!

Efocaine¹² is a specially balanced solution of procaine and butyl aminobenzoate in a non-toxic organic solvent that is completely miscible with body fluids in all proportions. This solution of anaesthetic agents (which are normally insoluble in water) is at saturation limits, so that the addition of even minimal quantities of water or body fluids, causes a complete and immediate precipitation of the active ingredients at the site of injection. Thus, upon injection into the tissues, the clear efocaine solution precipitates on contact with body fluids to form an anaesthetic depot. The solvent is excreted within twenty-four hours and the crystalline anaesthetic repository slowly liberates the drug for an extended period.

With the use of efocaine certain precautionary rules must be observed to develop maximum efficiency. They are as follows:

1. Only the deeper subcutaneous tissues should be injected, the injection should never be made intradermally or superficially as pooling of the drug will cause tissue erosion and slough.

2. Inject solution slowly and continuously as the needle is withdrawn to the skin edge, never inject towards the area, but have the needle inserted and inject while withdrawing.

3. The drug should be injected in a fan-wise manner to insure proper distribution of solution and to prevent pooling.

4. It must be emphasised that the injection of the drug should be halted when the superficial tissues are approached during withdrawal of the needle.

5. It is suggested that the needle not be completely withdrawn, but merely reinserted in another direction to insure the fan-wise distribution. Since it is best to use a twenty-two gauge needle, we try to keep the number of punctures at a minimum, preventing further traumatisation to the area.

METHOD OF INJECTION With procaine hydrochloride solution, using a small twenty-six gauge needle, a skin wheel is created proximal to the area of pathology. It is also advisable to inject carefully some of the solution directly into the painful area thereby insuring complete anaesthesia prior to the injection of the efocaine. Usually 2-4 c.c. of the xylocaine solution are sufficient to anaesthetise temporarily the painful area. Gentle massage will disperse the fluid quickly and insure prompt anaesthesia permitting us to go on to the second injection with efocaine. Using a twenty-two gauge needle, the efocaine solution is inserted into the anaesthetised area and the fan-wise method on injecting is begun. Again, let me emphasise—inject slowly and only as the needle is withdrawn towards the skin edge. Do not inject superficially and be ultra cautious of pooling the drug in any one spot. Try and infiltrate all the painful areas with just this one skin puncture by simply withdrawing back and reinserting in another direction, creating a fan-wise spread. If of course the area involved

is diffuse then another skin puncture and infiltration will have to be done. From 1-2 c.c. of efocaine solution has proved satisfactorily in controlling most ankle sprain pain. Good technique is of the utmost importance in the success of this treatment. Aspiration should be employed to prevent any possibility of an intravascular injection. If blood does show on aspiration merely withdraw the needle slightly and insert in another direction.

RESULTS Efocaine was utilised for post traumatic pain in fifteen cases of severe ankle sprain. It is to be noted that the use of the above drug merely affords symptomatic relief and was used in conjunction with compression and proper adhesive strapping. The results were classified in the following manner.

a. Excellent—Where no local pain in the injured area was experienced by the patient, either at rest or on weight-bearing.

b. Good—Very mild local pain under weight-bearing.

c. Failure—Where no pain relief was experienced.

Table No. 1

No. of cases.....15

Results

Excellent	9
Good	5
Failure	1

The anaesthetic duration averaged five days with a high of eight and a low of two. All patients were ambulatory after leaving the office and resumed the regular activity. The failure in the one case is believed to be the result of insufficient local infiltration of the drug. There was no evidence of local or systemic toxicity and no local tissue slough was noted.

SUMMARY 1. The rapid, almost dramatic relief of pain in the patient with ankle sprain, by the use of the prolonged local anaesthesia efocaine has been reported.

2. Although more cases are necessary to base any firm conclusions, it is hoped that a further and wider application of this drug be instituted.

3. The realisation of the frequency of ankle sprain and the necessity for pain relief and early ambulation (especially with service personnel) are both facilitated by the use of efocaine.

4. A series of fifteen patients were injected with efocaine and the results reported as follows: Excellent 9, Good 5, Failure 1.

5. Efocaine is a safe, effective and easily administered agent for the control of pain in severe ankle sprain.

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CLINICAL PHOTOGRAPHY * - Part II

by Gerald William Lundeen, D.S.C.

AS an ideal arrangement, it would be valuable to have one large view camera for photography in the office and a miniature camera for outside work. For greatest efficiency, the view camera should be mounted in a fixed place with standardised lighting equipment. Various portable lighting units are available for use with miniature cameras.

The most useful camera would be a 4 x 5 view camera. Many of them, besides using 4 x 5-inch sheet films and film packs, can accept 3½ x 4½-in. sheet film, and some have back adaptors which permit the use of roll film. Colour transparencies in the 4 x 5-in. size seldom need to be

enlarged, and contact prints suitable for most purposes can be provided from 4 x 5-in. black and white negatives. If colour transparencies are to be used for projection only, the more economical 3½ x 4½-in. film can be used. When 2 x 2-in. slides are wanted they can be obtained by duplication from the larger transparencies. As an alternative, a smaller view camera could be used, such as the 2½ x 3½-in. and/or 35 mm. films. A long bellows and sets of lenses with various focal lengths make view cameras especially suitable for dermatological photography in clinics and offices. These features permit the making of full size general views of a patient from a distance

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of six feet to close-ups of small skin lesions up to magnifications of about three times. It is easy to change rapidly from a black and white film to colour film, or to infra-red film without any waste of material. Also, the photographer does not have to wait until several exposures have been made before seeing the results in either black and white or colour film.

View cameras require some skill in handling; nevertheless, focusing by means of a ground glass and manipulating a tripod are not difficult procedures. However, these cameras are not readily suited for photographing patients outside the office. For such use a second, smaller camera should be used.

A small camera will appeal especially to those who are not interested in acquiring diversified photographic setups and skills and to those who will not wish to procure two cameras. If one camera has to do the work of both in the office and outside, a miniature camera is preferred, and will be satisfactory for all routine office records, for scientific work and field photography.

Such a camera is compact and easily carried. One small roll of film permits the taking of as many as 36 exposures, unless the eight exposure size 828 film is used. The film is relatively inexpensive; the processed Kodachrome slides are returned mounted, ready for projection. Little space is needed to store large numbers of photographs and it is convenient to mail and transport slides. For most purposes, the 35 mm. camera can be operated without a tripod. No dark-room is required. The use of a small camera alleviates fear and apprehension in nervous patients and makes the taking of a picture a seemingly minor procedure.

For dermatological work either type of camera has to be adaptable to making both close-up and regional views. Such

facility is available in most view type cameras. On the other hand, the average miniature camera cannot be used at a distance closer than about three feet without special arrangements.

One way to accomplish close focusing with miniature cameras is to increase the distance between the film and the lens. This can be done for some 35 mm. cameras by interposing extension tubes or rings between the camera body and the lens. Supplementary lenses on the lens of the camera will achieve a like result. These lenses are available in different strengths and can be used alone, or two can be employed in combination for greater magnification.

Unlike a bellows camera in close-up photography, most miniature roll-film cameras do not permit composing on a ground glass; neither can the ordinary view or range finders be used because they do not function at distances less than about 2½ feet. Some miniature cameras do accept special ground glass attachments; however, this necessitates the use of a tripod which is impractical if one must move around very much and wishes to keep one's amount of equipment to a minimum and as compact as possible.

View finding with a hand-held camera is best done with the use of some kind of focal frame. For close-up photography, especially, they eliminate the necessity of holding the eye close to the view finder or ground glass and enable the photographer to make the picture without having to assume an uncomfortable position.

One focusing device is provided for 35 mm. cameras that accepts extension rings; it comprises legs that can be screwed into the lens mount. These can be adjusted in length according to the depth of the ring utilised. The tips of the four legs determine the field size. This

type of arrangement gives satisfactory results. It does, however, necessitate care in making the adjustments when changing from one scale to another.

The use of supplementary lenses does away with the procedure of changing rings and simplifies the technique considerably. The methods employed for determining the distance and size of the

field as well as other factors in the construction and use of focal frames can be found by referring to information supplied with the supplementary lens by the manufacturer, and also by handbooks sold at most photographic leaders. If one is not handy with tools nor has the time to make a focal frame, there are several fine such frames available on the market.

Introduction to Below-Knee Appliances

by J. A. Sangster, M.R.S.L., A.R.I.P.H.H.

ALTHOUGH the prescription and application of below-knee appliances falls within the province of the qualified orthopaedist, a knowledge of their construction and function can be of great assistance to the chiropody practitioner who is called upon to treat the chiropodial aspects of a lower limb deformity necessitating the use of an appliance. Such appliances are, however, divided into two groups according to the purpose they fulfil. In the first group are the single and double below knee irons which are not, of course, weight-bearing but provide a fixed framework to which various straps and springs can be attached to correct malpositioning of the foot. The moulded leather supports with or without reinforcing steel strips, comprise the second group and these are provided when it is desired to give full support to the limb below the knee.

A double below knee iron with a toe-raising spring for instance, could be provided for a patient with the paralytic talipes equino-varus deformity associated with a lesion of the sciatic or external popliteal nerve. This appliance is constructed from two round steel bars, joined at their upper ends to a circular leather covered metal band which is fastened just below the head of the fibula with a buckle and strap. The lower ends of the bars

are turned in at right angles and fixed into circular sockets transversely placed in the heel of the patient's boot. The toe-raising part of the appliance is provided by a Y-shaped strap of leather attached to the circular leg band by means of buckles and the bottom of the Y is attached to a spring which is hooked to a metal D on the boot just in front of the lace opening. The lower end of a T-strap is stitched between the upper of the foot and the heel, while the upper end of this strap divides into two and encloses the ankle and one of the side irons. Cases of simple valgus or varus deformity, however, are usually corrected by a single side iron and the appropriate T-strap. It should be noted that T-straps are qualified by the disability they correct, e.g., varus T-strap or valgus T-strap.

In the above mentioned appliances, however, ankle movement is only obtained through the round socket let into the heel of the boot, but side irons are frequently provided with ankle hinge joints, in which case the heel socket is made fast. When the ankle hinge joint is prescribed then the toe-raising device mentioned above is replaced with a metal spring which passes down in front of one of the side irons, from the circular calf band to a projecting lug welded to the side iron

(continued on page 51)

NOW WE KNOW; ACTION IS WANTED

by G. Stanley Mercer

AT long last we know the worst, or best, whichever way one prefers to view it. The Minister of Health has made known the regulations governing the employment of medical auxiliaries in the National Health Service. Chiropodists, dieticians, medical laboratory technicians, and physiotherapists are among those concerned.

The pattern of the regulations is very much as forecast in this journal by the Editor and myself. The Minister has been scrupulously fair and has refused to be influenced by sectional interests. Indeed, one might say that he has, with almost a stroke of his pen, administered to the chiropodial isolationists a decisive blow from which I can see no recovery.

The regulations provide that members of both the Joint Council of Chiropodists and the Society of Chiropodists, are eligible for employment in the Health Service, *provided they have received a two years' training course.* The training stipulation does provide an advantage to Society members as the majority fulfil this particular requirement. But there still remains a large group of Society members who do not. And so we find many high ranking members of both the Joint Council and Society left out of the reckoning. In a practical sense, they are not seriously injured, as for the most part they are firmly established in private practice and not very interested in hospital appointments. Those who already hold appointments are unaffected by the regulation. I wonder what the feelings of this old school of chiropodists must be. It is *ironical* that many of their own trainees qualify for an increased status denied to them. But they should not worry unduly.

A careful study of the regulations reveals a certain looseness which seems to have been purposely designed to enable the Minister to bring into the scheme anyone he believes to be deserving of the privilege. I am, however, tempted to suggest that had the Society responded to the Joint Council's invitation to confer jointly, the Minister might have been persuaded to make clear provision for the entry into the scheme of all those earlier members who passed the qualifying examinations, but did not receive the advantage of two years' training. Records in my possession reveal that this was one of the subjects the Joint Council wished to discuss with the Society. If the pride of those earlier members has been touched they know where the responsibility lies.

In effect the Minister has pronounced that two years' chiropodial training is adequate. He realises no doubt that a longer period does not fit the narrow field of operation a chiropodist is required to observe. What will the Society's reaction be to this? Only recently it extended its prescribed training period to three years. In the changed circumstances that third year seems to be quite pointless. In this connection developments will be most interesting to watch.

And in what kind of a spot does the Board of Registration of Medical Auxiliaries find itself? The Minister's regulations make no reference whatever to that body. I rather think the reason is that he has recognised as qualifying bodies organisations outside the present jurisdiction of the board, most prominent of which are the Chartered Society of Physiotherapy and the Joint Council of Chiropodists.

My immediate reaction is that the

B.R.M.A. becomes almost redundant. Try as I will, I cannot see what useful purpose it can now serve. If it does become redundant the board has only itself to blame. Its original function was to establish a close and mutual relationship between the medical and medical auxiliary professions, an ideal which at the time received my personal and practical support. But the board has failed lamentably.

The Minister's regulations change almost overnight the whole structure of the chiropodial outlook. He has by the very terms of his regulations put an abrupt end to isolationism and welded the profession into a unit. He has given the two major organisations an official status of strict equality. He will demand of them both a close co-operation to enable him to apply his regulations efficiently and effectively. He may even expect one, or both, to sink its present identity and move forward under one banner.

As a result of the new position in which

the profession now finds itself there are certain to be repercussions. Recriminations and perhaps resignations from high office are possible. But do not waste time in holding a major inquest on past mistakes. The organised profession must tear down the shutters and go forward with all possible speed.

A review of recent pronouncements in the House of Commons makes it abundantly clear that the Minister's recent regulations are merely a prelude to the introduction of the much greater issue of complete state registration. It will be a sorry day for the profession if the Minister concerned is forced to name the terms himself. He must have the advantage of proper guidance by means of a consultative body in respect of each of the professions concerned. And that means the immediate election of such a body representative of the Joint Council and Society. For heaven's sake, get on with it.

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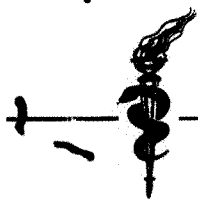
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Round and About

by "Vigilant"



A GREAT MAN PASSES

The profession has suffered a sad and severe blow in the passing of Mr. E. G. V. Runting in his ninety-third year. I cannot claim the privilege of having known Mr. Runting intimately, but I knew him sufficiently well to honour his name by stating that he was one of the finest gentlemen I ever met. He was a pioneer of the profession, indeed one might almost say *the* pioneer. The advance of the profession to its present high status was the direct result of his early endeavours. He never isolated himself in either his private or professional life. How well I recall his greatheartedness when this journal was first produced. At that time it was the official publication of the British Association of Chiropodists. I asked him for a message of goodwill for our readers. Unhesitatingly he gave that message and followed it by contributions of various kinds.

The colour of the professional qualification did not matter to Mr. Runting. Provided he was practising ethically, a chiropodist was a friend to him. What an example for so many others to follow.

I should like to extend to Mr. Runting's family my deep sympathy on their great loss.

THE MINISTER STEPS IN

In the simplest of terms the Minister of Health has formulated regulations for the employment of chiropodists in the

National Health Service. This matter is dealt with fully by others in this issue, and so I leave the details to them.

The most important development is the strict equality of qualification extended to both the Joint Council of Chiropodists and the Society of Chiropodists. There is jubilation in the former camp and bitter disappointment in the latter. Already I have discussed the changed position with chiropodists of both groups, some prominent. Here is a small selection from the many comments:

My organisation must content itself that it did all the donkey work for others to benefit.—A member of the Society.

Not only have the profession's isolationists received the thrashing they have asked for, but also the B.M.A. and B.R.M.A. as well. — Joint Council member.

Nothing can deprive my organisation of the supremacy of its exclusive status. Those responsible for selecting candidates for hospital work and know the respective qualification values will prefer our members.—A member of the Society.

Those who have mis-directed chiropodial policy for so many years have surely received their marching orders. — Joint Council member.

The Minister has had his eye more on votes than the interests of the medical auxiliary professions.—A member of the Society.

Controversy will be ripe for a while to come, but I expect soon the profession

as a whole will settle down to the new conditions.

FUTURE OF B.R.M.A.

As a result of the Minister's new regulations, there is considerable speculation as to the future of the B.R.M.A. Two well informed practitioners are quite confident that as a registration authority its days are numbered. On the surface this seems highly probable, but it is too early for me to speculate.

HE OR SHE

The other day I found myself involved in a good humoured argument, as to whether men or women make the best chiropodists. I was able to stir the argument up, but discreetly refrained from expressing an opinion. On behalf of the ladies it was said that they are very meticulous, take their time, exercise more patience and are not the butchers that many men are. For the men, it was claimed that they

are lighter of hand, and cleaner in their paring, due to being able to use the strops more effectively.

INDIGNITY OF THE OLD SCHOOL

There are many hundreds of the older established chiropodists who fail to qualify for hospital employment under the new regulations. I hear whispers of their getting together to get what they call "this indignity" corrected. I don't think they need get too excited. Those who want to will get in without difficulty, I'm sure.

ADVERTISING: A TIGHTENING-UP

Those very naughty members who have been indulging in sneaky advertising had better look out. In view of recent events I have reason to suppose that both chiropodial organisations are rigidly to enforce their rules on the matter of publicity.

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ABSTRACTS

From Our Contemporaries

Current Chiropody, New York

FROM AN ARTICLE by L. F. Schreiber, Pod.D., entitled "Are Bacteria Specific Agents of Infectious Disease." Dealing with the generally accepted idea of the impossibility of spontaneous generation of bacterial cells, he says:

But even the doctrine of spontaneous generation has been revived in recent years. Dr. Wendell M. Stanley, of the Rockefeller Foundation for Medical Research, after reporting how inert crystals could be transformed into the self-reproducing virus of the plant cancer, tobacco mosaic, declared that heterogenesis (spontaneous generation) must now be considered a possibility in nature.

In short, the "classical" germ theory of disease seems slated for considerable revision, and with it, conventional methods of the treatment of infectious much, he is ready, also, for a perusal of a rather small but remarkable book, *Bacteria, Inc.* Clearly and dramatically written, it is basically a book against vaccination.

The author assembles the views of a number of bacteriologists and physicians on the subject of vaccination. If one or two of these statements be taken seriously, the result is likely to be unsettling to the mind of the reader schooled in the doctrines of regular medicine.

What is of use in such books as *Bacteria, Inc.* is the invitation to a new kind of learning. No single reviewer, lay or specialist, could possibly confirm or deny all that will be found in this book; but no reader should be able to set it down without wanting to do some thinking for himself. It is rather significant of the

times that medical facts of a new sort are piling up from diverse sources—the rapid, almost revolutionary changes in all branches of learning, in world attitudes, in general science, in fact in all departments of civilisation, point the way, the road now being travelled as new ideas replace the old.

In this regard we respect the wisdom of Plato, who said: "Ideas rule the world."

From "Chiropody Reflections"

WE CAN all recall our training days and the avidity with which we followed our lectures. Then a new field was being opened for us and new possibilities being advanced. Theory and practice then lead to a so-called completion of studies and, alas, our books are then put up on the shelf to collect the dust of years. The student sits back with a feeling of something achieved, yet the real work is then only starting. Private practice affords, to those who wish it, the real chance to learn, if only through the mistakes we all make. But so often it happens that the practising chiropodist becomes smug and complacent, feeling that all is known, or the hard period of training over and done with.

and from the Editorial by Roger A. A. de Bryon-Faes:

Well-founded reports are filtering through to the effect that a third chiropodial body is to be established. Composed of members of an existing organisation and non-chiropodists, it will, for the fee of three guineas, grant a "measure of recognition" and a new set of rules to those who desire to be "registered." In other words, the wedge is to be driven more firmly into the cleavage of professional chiropody in New South Wales. As it is a voluntary entity, with no legal authority, chiropodists who believe in unity in the profession would be well advised to refrain from associating with

such an undertaking, at least, until the true purposes of such a body are publicised. After all, the vague promise of a few part-time 'hospital-appointments' does not warrant the surrendering of chiropody's identity or independence.

Journal of N.A.Ch., (U.S.A.)

HAIR GROWTH on toes of gangrenous extremities is a valuable prognostic sign influencing the decision to amputate. Blood flow sufficient to maintain active growth of hair probably also is adequate to heal necrotic lesions, remarks Meyer Naide, M.D., of the University of Pennsylvania, Philadelphia. Most healthy persons have hair on the toes. Male patients less than 50 years of age usually have 15 to 20 hairs on the great digit; women have somewhat fewer. The count decreases with the severity of ischemia. A normal amount of hair or regrowth of blond hair, later turning black, during medical treatment or after lumbar sympathectomy indicates establishment of sufficient collateral circulation to assure healing. The sign was diagnostically significant in 173 patients with popliteal or femoral arterial occlusion, including 53 subjects with gangrene; 17 of the latter required amputation.

New England J. Med. 248:179-182, 1953.

FLAT FEET are a common deformity in children. If correctly early, the child will be spared unnecessary crippling and handicaps in his adult life. Children with flat feet tend to have knock-knees, and stooped or rounded backs. Their feet may ache after walking or standing, and they are disinclined to run and play with other children. They may become self-conscious about the looks of their feet. Flat feet tend to be hereditary. The flat-footed baby's first shoes should be chosen carefully, if possible with a doctor's help. As the child stands and walks, weight should be thrown to the

outside of the foot and shoe, and the child taught to walk with feet on skin instead of "toed out." At 5 to 6 years, certain exercises should be taught to strengthen the feet in this and prevent rigid, painful feet, e.g., fallen arches. Feet should be examined at least once a year to check on the progress of the condition. Children with normal feet should have properly fitted shoes so that they will not develop disabling disorders such as callouses and bunions. Discarding shoes that are too small is the better part of economy, for blisters and ingrown toenails can result in dangerous infections. The lifetime handicap of bad feet is almost always avoidable.

Ladies' Home Journal, June, 1953, "Your Child Needs Good Feet!" by Dr. Herman M. Bundesen.

Chiropody Review (London).

TO MEASURE the size of a patient's calf is a most useful diagnostic procedure, especially in view of the fact that the size of the two calves can be compared. This clinical test may be useful, for example, in acute conditions such as thrombophlebitis of the leg veins, and it is a most important observation to make in chronic diseases of both muscle and nerve.

What difference between the two sides is normal, however; in other words, do the diameters of the right and the left calf vary, for example, with occupations? An interesting investigation to settle the point was undertaken in the United States, recently. A large group of vehicle drivers had their calves measured. The activity of their respective legs were first considered, and it was found that the right foot was in use for 99 per cent of the time, whereas the left foot was in use for only 48 per cent of the time. It would have been guessed that the difference between the right calf and the left would

greater than would be the case in the union at large, but the investigation at this was not true; in fact, shown by at least one observer use may actually diminish

the circumference of the calf.

The same experiment was repeated in a series of working women, and there was no significant difference between one calf and the other.

BELLOW KNEE APPLIANCES

(continued from page 44)

below the hinge joint. In a minor degree of foot drop the toe-raising spring is usually dispensed with entirely and plantar flexion is prevented by fixing a back stop, a short metal upward projection from the heel socket, directly behind one of the side irons.

When it is desired to provide weight-bearing support below the knee, perhaps for an un-united fracture of the tibia or fibula or if the surgeon considers that the patient should be ambulated where a delayed union exists, then the second group of below knee appliances are used. They are normally made of blocked leather moulded to the patient's leg, with frontal lacing. Two side steels are incorporated and extend downwards to be inserted into heel sockets.

Great care is taken in the construction of these weight-bearing appliances. The leather is accurately moulded to a plaster cast of the limb and ensures an exact fitting around the upper ends of the tibia and fibula. The frontal lacing is placed so as to avoid the sharp anterior tibial edge.

More familiar to the chiropodist perhaps than the foregoing appliances, are wedges and metatarsal bars. These additions to the patient's footwear are frequently prescribed by the orthopaedic surgeon for conditions with which the chiropodist has a day-to-day acquaintance. Wedges however, are raisings of the sole and heel on the inner side of the footwear and can be made up to $\frac{1}{2}$ in. thick. This

attempts to correct a mild valgus deformity although for a weak foot or pes planus, only the heel is wedged. Continuing the heel forward on the inner side to form an oblique heel is also frequently ordered to support the inner side of the foot.

From the chiropodial point of view, the function of metatarsal pads and strappings is well-known but the orthopaedic aspect is treated by the application of metatarsal bars to the patient's footwear. These are placed externally across the sole of the boot or shoe immediately behind the metatarsal heads and are about $\frac{1}{4}$ in. thick and up to 1 in. broad. To relieve extremely painful weight-bearing on the metatarsal heads, some surgeons favour placing the bar further back and making it about $\frac{1}{2}$ in. behind and $\frac{1}{4}$ in. in front. It is placed approximately at the junction of the waist of the boot and the sole. This means that the metatarsal heads fall on a downward slope and are therefore saved the full thrust of weight-bearing. Strained metatarsal-phalangeal joints are relieved in a similar manner. Reduction of dorsiflexion is obtained by increasing the thickness of the whole sole or as is sometimes prescribed, the posterior half of the sole only. This device is also employed to alleviate an osteo-arthritic condition of the hallux.

The chiropodist who has the privilege of treating a few orthopaedic cases is indeed fortunate, because he can learn much that will be of professional value from studying the mechanics of the various appliances and adaptations so briefly described above.

QUERIES

Answered by F.A.D.

PLASTER IRRITATION

Q *Can you offer any reason why a patient of mine, a middle aged lady, who has been accustomed to adhesive dressings should suddenly develop plaster irritation and rash, and how can such occurrences be prevented?*

A There is in such cases more than one possible cause, and the trouble may arise from a combination of more than one of them. For example, it may result from skin fatigue arising from interference with skin function over a long period, or from stresses to which the skin has been subjected through traction applied to the skin either intentionally or accidentally, or from prolonged contact with the chemical content of the adhesive without having allowed between applications a day or two rest period for air and water to reach, aerate and cleanse the skin; it may be encouraged by local heat generation from constant wearing of gum-boots, which allow insufficient aeration and harbour condensation, or—at this season—from constantly worn tight-fitting wool-lined bootees dragging on the dressings under conditions of moist warmth.

It is interesting to note that recently Dr. R. E. Humphries, in the U.S.A., published a report on his investigation into the adhesives applied to plasters and secured the co-operation of one of the large rubber companies over a period of 2 years during which some 427 patients were under observation. Using normal adhesive plaster dressings he found that some 130 developed irritation, but when fatty acid salts were added to the adhesive the number was reduced to 5. The final conclusion was that the addition of zinc salts of propionic and caprylic acids to adhesive tape formula caused better

adhesion, less pruritis and a marked reduction in plaster dermatitis and less maceration.

Personally, I think that such a proportion of cases is unheard of in this country, and this may be a tribute to the manufacturers in providing us with excellent adhesives. In twenty years of practice I can say that such cases have been rare in my own experience and that of my close associates, and although I may be mistaken, I am inclined to ascribe this rarity of occurrence to care in the application of strappings and an ineradicable habit of painting the skin with a light coating of Tinc. Benz. Co., prior to applying plaster; in this way direct contact between plaster and skin is virtually avoided and the risk of chemical irritation minimised, and the plaster adheres with greater facility and uniformity with a reduction of mechanical irritation. Incidentally, I have only seen one single case where the Tinc. Benz. Co. itself, without plaster, gave rise to irritation. Patients are always given to understand, at their first visit, that should they experience any irritation either under or around the dressings, they should return to the surgery for inspection. In this way anything serious in the way of dermatitis is forestalled.

Applications which I have found useful are, for mild redness and irritation, calamine lotion or witch hazel lotion; where a rash has developed, acriflavine lotion, 1/1000; where the rash has further developed to the vesicular stage, acriflavine or preferably, proflavine emulsion, 1/1000; as a drying powder, zinc stearate may be applied on gauze with good results.

The principles of treatment are, removal of the cause, reduction of inflammation, oedema, irritation, emptying and antiseptic treatment of vesicles and bullae if present, and constant guard against infection from external sources. Rest of the limb may be imposed in severe cases.

NOTES AND NEWS

New Chiropody School

A SCHOOL OF CHIROPODY may be established in Hull, Yorks., before the end of the year, according to Mr. W. L. Robinson, chairman and founder of the Hull and East Riding branch of the Joint Council of Chiropodists. In his speech at the annual meeting of the branch, held recently at the Royal Station Hotel, Hull, he also said that the branch was going from strength to strength and were well on the way towards their ultimate goal of registration.

Officers re-elected at the meeting were Dr. P. M. Scott as president, Mr. W. L. Robinson as chairman, Mr. W. G. Haller as secretary, Mr. R. Cook as treasurer, and Mr. C. Millington as conference delegate.

Exercises for Children

REMEDIAL EXERCISE CLASSES to correct foot defects form part of the London County Council's School Health Service. Introduced in 1948 to save children from developing permanent disabilities of the feet, these classes are now taken for 65 different groups of children in London.

Foot Service Praised

LIVERPOOL FOOT HOSPITAL gave over 21,000 treatments last year, and its staff of seventeen chiropodists, all of whom do voluntary work, was complimented recently by the Lord Mayor of Liverpool, who called the enterprise "a most important piece of social service." But the hospital finished the year £1,710 in debt, and despite a £750 grant from the city council it is still likely to have a deficit of £1,000 at the end of the current year. Major Webster, chairman of the hospital

committee, was however confident that they would get additional support if the work were more widely known.

Corporation Challenged

THE MINISTER OF HEALTH has declared that Wolverhampton Corporation incorrectly interpreted recently the regulations about the appointment of a part-time chiropodist for their welfare service. This followed a protest from the Joint Council of Chiropodists that the wording of the advertisement showed discrimination against them; it invited applications from registered members of the Society of Chiropodists included in the national register of medical auxiliary services for the post.

After further protest to the corporation, the Joint Council asked Mr. J. Enoch Powell, M.P. for Wolverhampton South-West, to take up the matter. When he raised the subject in Parliament, Miss Pat Hornsby-Smith, replying for the Minister, said that the Wolverhampton Welfare Services Committee thought that, because the chiropodist to be employed under the health scheme had to be trained at a school recognised by the Society of Chiropodists, this was coincident with membership of the society.

The council's supposition was, in fact, incorrect, as the Ministry understood that not all members of the society had been trained at one of the society's schools and passed their examinations. Wolverhampton Corporation were being informed of this distinction.

New regulations dealing with the qualifications of medical auxiliaries, which would alter the position and make it possible for members of the Joint Council

of Chiropodists to be employed in the National Health Service had now been drawn up by the Minister.

Shoes Ban?

PROHIBITING THE MANUFACTURE of other than healthy shoes is proposed by Dr. G. G. Sherriff, of London, in the *Medical Officer*. He believes that the problem of bad feet would then disappear. Complaining that it was impossible to buy shoes which fitted the natural shape of the feet, except for some children's shoes, he declared that shoe manufacturers would not remedy the matter until they were forced to do so.

Licence Application

A LICENCE to start a chiropody and massage clinic in Marylebone, London, was granted recently to Mr. C. N. Gilbert, against opposition from the London County Council. More than 40 references were produced to support his application.

Opposing the application was Mr. R. J. McDowall, chief public control officer of the L.C.C. He said Mr. Gilbert was at the Chelsea School of Chiropody for three years instead of the usual two years.

Mr. C. E. Kemp, head of the Chelsea School of Chiropody, who stated that Mr. Gilbert failed the final examination "very badly," was asked if he knew that Mr. Gilbert's mother was in hospital at the time, likely to die at any moment, and that he was suffering from severe nerve strain at the time of the examination.

Mr. Kemp said that had happened at every examination.

Mr. Gilbert said that he gave 1,597 treatments under supervision while training. From 1951 to 1953 he carried on a visiting practice, in the course of which he treated some 100 patients.

Counsel said that it was quite clear that

Mr. Gilbert's relations at the school were not happy, and perhaps there was a little tension, but he was not complaining about that.

The mere fact that Mr. Gilbert failed was not conclusive against him. He could not see how a man who could produce testimonials like Mr. Gilbert had could be prejudiced for the rest of his life.

Chiropodist Lectures

A SECOND TALK was given recently to members of the Birmingham branch of the Boot Trades Association by Mr. P. A. Hayward, of the Birmingham General Dispensary School of Chiropody. At his first talk Mr. Hayward dealt with the problems of shoe fitting, and in his second he outlined the construction and working of the foot. He emphasised that toes played a more important part in bearing weight when walking and were more often the cause of pain than many people imagined. He welcomed the fact that more attention was being paid to the care of children's feet and the wearing of proper shoes.

Scholl Celebration

TO CELEBRATE the 70th birthday of Mr. F. J. Scholl last month, the staff of the Scholl organisation in this country presented him with a cocktail cabinet. His brother, Dr. William Scholl, came over from America for the ceremony.

Students See Shoe Factory

A PARTY of 23 chiropody students and staff of the London Foot Hospital, led by Mr. M. D. England, F.Ch.S., senior lecturer, recently visited the factories of the Norvic Shoe Co., Ltd., in Norwich. They took part in a practical demonstration of shoe-fitting, held in the replica of a modern shoe shop, which now forms

part of the Norvic main showroom.

At a lunch presided over by Mr. A. A. Parker, the managing director, Mr. England thanked the Norvic Company for the facilities they had provided for the students, and congratulated the company on its interest in foot-fitting problems.

The visit, which was the second of its kind, formed the students' annual outing, and followed interest aroused by Norvic displays at the last two annual conventions of the Society of Chiropodists held in London.

Schemes for the Aged

THREE PARTS of central London are extending their chiropody services. Paddington Old People's Welfare Committee have increased the period when treatment is available from a half day to a whole day each week; St. Marylebone Old People's Welfare Association have found the demand for their chiropody service so heavy that appointments have to be booked two months ahead, although the charge has been raised to 1s. 6d. In St. Pancras the Association for the Care of the Aged are to have the use of accommodation at the Kentish Town Maternity and Child Welfare Centre for a foot clinic.

TEDDINGTON, Middx., now has five chiropody clinics for old people, covering the district and 600 patients have been treated in the past year. In some cases transport has been provided and in others chiropodists have visited the homes of the patients.

THE ARGYLL, Scotland, branch of the British Red Cross have provided a chiropody service for old age pensioners in the Cowal and Kintyre areas, where it is extensively used and greatly appreciated. The extension of the service to other parts of Argyllshire is being considered, but

it has been found impossible to operate a similar service in Islay where there is also a need for it. The Argyll County Council are now prepared to undertake the service in the island of Islay.

CHIROPODY at reduced prices is now available for people over 60 in Tottington, near Bury, Lancs. Clinics, planned by the local Old People's Welfare Association, will be held every month in the association's headquarters at the Friendship Hall. Old people unable to attend will be visited in their homes.

THE COST of a chiropody service for the old people of the borough of Southwark, London, is being partly met by the Southwark Council. They have granted £50 towards the cost of the service which is carried out by Mr. Howard Tertis.

THE CHIROPODY SCHEME for old people in Petersfield and district, in Hampshire, began recently at the Red Cross centre in the town. There is a scheme for taking chiropody to the surrounding villages for elderly people.

THE CHIROPODY SCHEME, provided by Sheffield committee of the Confectioners' Benevolent Fund for elderly people of the confectionery trade in the Sheffield area, has been praised recently as one of the finest things they have ever done, so great is the need of old people in this connection.

THE FREE FOOT CLINIC in Exeter, Devon, for elderly people has now been run by the British Red Cross Society for nine years.

CHIROPODY is one of the treatments which may be recommended by the new assessment unit, the latest addition to the geriatric section of the Royal Alexandra Infirmary at Paisley, Scotland.

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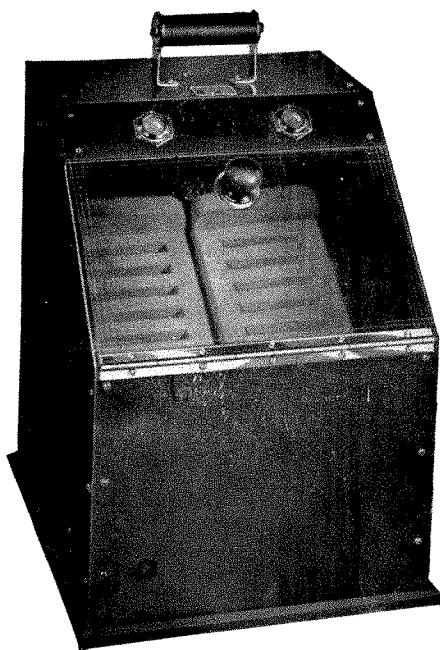
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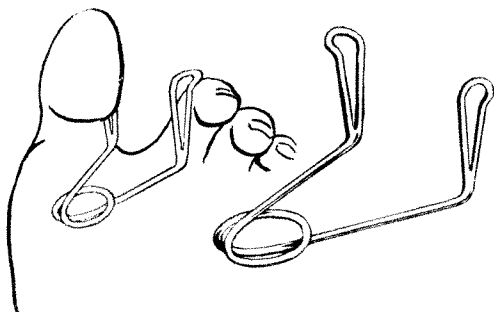
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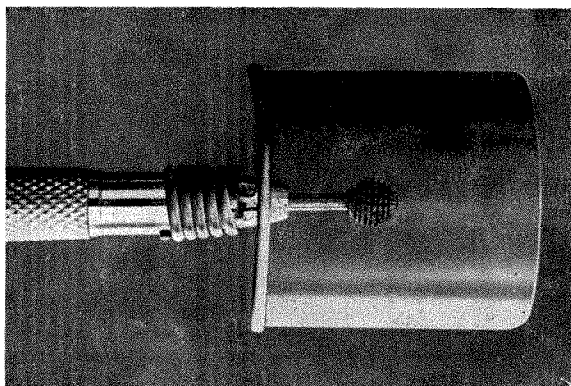
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REFLECTIONS To the average chiropodist practising privately the recently published regulations of the M.O.H. must appear as a mere ripple on the surface of a muddy pool, a movement occasioned not by the presence of life within the stagnant waters, but by the cool breeze from the M.O.H. without. His reactions will probably be to shrug his shoulders, say "So what?" and then turn again to the immediate and more familiar problems of the practical chiropody by which he lives.

Throughout the years many have been the hints of progress, professional dignity and worthy status, which would follow our humble submission to the restrictions of the B.M.A. and the B.R.M.A., but it should now be plain for all to see that whilst the B.M.A. has succeeded only too well in controlling and limiting the scope of our activities in a field hitherto neglected by themselves, they have done absolutely nothing either directly or through the B.R.M.A. to seek for chiropody that legal protection which alone can assure for our profession the cessation of the constant invasion by opportunists, which makes the "pool" so muddy, and which does more to keep our profession

down to a corn-cutting status than any other one factor.

Many are the learned theories as to why corns form and nails deform, but in the end the theorists descend and the opportunists ascend to meet on a common plane of practical activity where they try to earn their living by treating corns, the presence of which the one may understand whilst the other may not, but which are plain for both to see and none too easy to eliminate.

The two policies, that of a highly trained and skilled profession with periods of two and three years' full-time training, and that of the ever-open door to all comers without exception, are completely and diametrically opposed and cannot co-exist without the former suffering eventually to a point of futility.

EQUALITY The M.O.H. has named both the Society and the J.C.C. as appropriate bodies for the issue of qualifying certificates to medical auxiliaries, and by a later letter has asked that they both submit details of their approved training and examinations for his approval.

Further each organisation will supply two representatives to sit on a so-called

working party to discuss suggestions made by the professional bodies.

This applies to all the other medical auxiliary bodies also, so the working party will be a very mixed affair. However, the Society and the J.C.C. can claim equality of treatment.

Equality of treatment does not always produce equality of results and the equality accorded to the two bodies is not in the nature of an equality of opportunity of proving their merits. We feel sure that the Society will be able to produce the proofs needed of their training and examination system in detail, and the J.C.C. may be relied upon to do their utmost also in this direction in spite of past handicaps.

It must be borne in mind that the principal object of all this is to enable the Minister to determine who is to be recognised as eligible for employment under the N.H.S., although, as we said in our last Editorial, such a list, if sufficiently comprehensive, could possibly serve as a basis for a national register at some future date in the dim distant future. We would rather see a register formed now to determine who can practise anywhere in Britain as a chiropodist and not only under the N.H.S. Such a register if it were in being, could not be other than for the benefit of chiropody as a whole as it could serve no sectional interest.

CHANGE OF OUTLOOK A change of outlook is vitally necessary, away from the hypnotic influence of a few jobs under the N.H.S., away from officialdom and its inhibitions, and towards the open air of private practice with its freedom of expression and progressive possibilities, building up a wealth of public support for the legislation we should undoubtedly seek to obtain. By this we do not mean that we should cease to value hospital and other official posts, but rather that we should cease to overvalue them, that we

should cease to look on them as the hub around which our chiropodial lives revolve and cease to cultivate the idea that such positions should set the standard of remuneration for professional employment.

The recommendations of the Cope Committee are dead and the M.O.H. has struck a note of equality between the Society and the J.C.C. We can expect nothing from the B.M.A. or the B.R.M.A. as such, whatever goodwill certain individuals may bear towards our profession, and it is obvious that after all these years chiropody is not making the advancement towards professional status which it deserves and must therefore rely first and foremost upon chiropodists for their future. The first thing is to be realistic and to see clearly that whilst the Society is clinging to the idea that they are better than the J.C.C. and refusing consultation with them, they are simply allowing hundreds to pass into the profession through the back door who are not nearly as good as either. These two organisations must take the lead, but they must do it in unison. There has been a fight, the referee has stepped in, awarded points, and there is no winner; surely they can agree to fight in future for their common interests and together set themselves a course of action in the interest of the future of the profession which transcends that of the individual organisation.

So far this profession of chiropody has had to bow the knee to all and sundry, the physio-therapists and all the company of medical auxiliaries with whom we are herded. It is time we changed our outlook and gave up everything which impedes progress towards legislation for an independent chiropodial profession. We believe that the Society will find that the J.C.C. understand and would co-operate in such action.

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THE IMPORTANCE OF THE LUMBRICALS

and Interossei in Metatarsalgia

by B. Dalton, M.Ch.S.

CHIROPODIAL literature makes little mention of the lumbricals and interossei when regarding the causes of metatarsalgia. Although this latter term is collective, non-function of the anterior transverse metatarsal arch constitutes the major element accounting for pain in the ball of the foot. This disturbance is most frequently brought about by the failure of these little muscles.

Individually speaking they might be deemed insignificant and almost superfluous. Nevertheless, for the maintenance of equipoise between the long flexors and extensors of the toes, their weak action is perfectly adequate. A more powerful exertion would defeat the object of Nature's wonderful economy and be totally unnecessary. From a mechanical aspect it is sufficient only to maintain the proximal phalanges of the toes in a state of equilibrium in order to establish the equipollence of the long flexors and extensors. Once the stability of the above mentioned bones is lost the toes begin to claw.

Referring to the anatomy of the lumbricals and interossei, it is interesting to note that they have two actions in common, viz.: they all flex the metatarsophalangeal joints and they all extend the interphalangeal joints. It is known that the lumbricals are inserted into the plantar aspect of the aponeuroses of the extensor digitorum longus; but it may not be widely realised that the dorsal and plantar interossei are also inserted into the same aponeuroses as well as into the lateral and medial surfaces of the bases of the proximal phalanges.¹ Thus, clearly, all these muscles acting together constitute a very efficient support as Levick² has

demonstrated by electrical stimulation.

In his study of claw foot Lambrinudi³ discovered that once the phalanges were balanced in relation to the metatarsals, a marked improvement in the clawing of the foot was achieved; in other words, once the toes were straightened by arthrodesis the whole balance of the foot was improved. Levick discovered that stimulation of the lumbricals and interossei caused an arching of the metatarsal heads, the keystone being the second. This seems to indicate that with fatigued or otherwise disfunctioning lumbricals and interossei an overloading of the metatarsal heads would result.

The excess loading is achieved as follows: When the interossei and lumbricals cease their action, the long extensors and flexors of the toes over-act in order to take up the slackness resulting from the "crumpling up" of the toes. This concertina effect follows from the uneven pull of the long extensor and flexor. In the normal foot there exists an obtuse angle between the axis of the metatarsal and that of the toe, (see Fig. 1). This angle is made more acute by contraction of the long extensor and is the first movement resulting from such contraction; this is even more

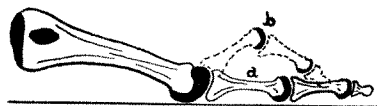


Figure 1. "a" represents the angle normally present between the metatarsal and toe. The dotted outline "b" represents the exaggerated angle in clawing of the toes.

exaggerated by the action of the flexor. When this latter muscle acts and pulls on the base of the distal phalanx, it carries with it the medial phalanx, but not the proximal one, which is held in extension by the extensor; continued action of the flexor bends the proximal interphalangeal joint, allowing more extension to take place at the metatarso-phalangeal joint.

This action is progressive and is dependent on the continued disfunction of the interossei and lumbricals. Now when there is a degree of clawing present, there is also a degree of overloading on the metatarsal heads by the backward and

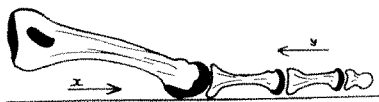


Figure 2. In the normal foot the forward movement of the forefoot on weight-bearing, "x" and the force of reaction, "y" are in the same plane.

downward pressure of the proximal phalanx, resulting from and reactionary to the forward movement of the forefoot on weight-bearing; this backward force on the metatarsal head is equivalent to the body weight. In the normal foot this reactionary force is absorbed by the toe, but in the case of clawing, it is transmitted to the point of contact between the ground and the metatarsal head. (see Figs. 2 and 3). Again, normally the reactionary force to the forward movement of the forefoot is the force of friction. But when this

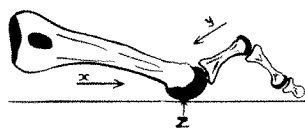


Figure 3. In claw toe the forward movement of the forefoot on weight-bearing, "x," and the force of reaction, "y," are not in the same plane. They have a point of focus, "z".

reaction is transmitted to the skin by clawing, there immediately arises an excess friction in that area. Clearly, then, there is an abnormal distribution of forces in the metatarsal area, which may result in callous or simply inflammatory results of excess strain, depending on the tone of the skin and its degree of elasticity.

CONCLUSION Failure of the lumbricals and interossei, or their weakness, which may be due to many causes, constitutional and local, results in overloading of the metatarsals. It is perhaps more fitting to speak of "overloading" rather than "dropping" or "depression." This overloading may be temporary or permanent, depending on whether the lumbricals and interossei are functioning to some extent or are paralysed. The results of the excess strain may be anything from pain and discomfort to permanent callous, corns, or fibrosis.

References

1. Gray's Anatomy, Myology, p. 609.
2. Wood Jones, The Foot, p. 262.
3. Mercer, Orthopaedic Surgery, pp. 682-3.

HALLUX VALGUS SURGERY CRITICISED

SPEAKING before the 310th meeting of the Academy of Podiatry at Hunter College, New York City, recently, Dr. M. D. Roven, Brooklyn chiroprapist stated that hallux valgus, and particularly hallux

rigidus surgery, was uncertain and frequently led to a stiff joint.

Dr. Roven is a lecturer at the Long Island University College of Podiatry in New York and is one of the contributing

authors to the text book *Modern Foot Therapy*. In World War II, he was Lieutenant, podiatrist specialist in the U.S. Navy, in charge of foot clinics for Marine and Navy installations in California.

In a review of more than 800 cases, it was shown that in most instances surgery of any type did not improve the joint, and in some, surgery created an even more painful foot. Orthodigital therapy, in the form of traction therapy, toe slings and "bunion jackets," was recommended over any surgical procedure. A case of hallux rigidus was shown in which X-rays revealed an overall increase of one millimetre of joint space with complete elimination of pain, after traction therapy.

Dr. Roven also stated that footgear as a cause of hallux valgus was exaggerated. While it was true that improper shoes played a contributing role in the formation of hallux valgus, it also developed in primitive populations who had never worn shoes. The aetiology lay in the weakness

or defect in architecture of the foot such as metatarsus varus primus, hypermobile of the first metatarsal segment, or foot imbalance creating improper distribution of weight-stresses on the forefoot.

On the same programme, Dr. Marvin D. Steinberg who is attending podiatrist at Memorial Hospital, a member of the New York Academy of Scientists and the American Society for the Advancement of Science, showed slides of neoplasms involving the foot. He stated that surgery for such lesions as subungual exostosis, verruca, fibroma, granuloma pyogenicum and cysts rightfully belong in the office of the chiropodist and should be performed as a routine. Simplified techniques for such surgery were explained. Twenty-six cases of glomus tumour and fifty cases of what he called "plugged duct cysts," were mentioned and the importance for histological sections of all neoplasms was stressed.

THE WEAKFOOT CONCEPT* —Part I

by L. F. Schreiber, F.A.A.C. (Hon.), F.A.C.F.O., and
H. W. Weinerman, D.S.C.

THE weakfoot concept has survived a life history of more than two generations. It was originally promulgated by the eminent Royal Whitman in his monumental textbook on orthopaedic surgery¹, which passed through many revised editions, the concept having gained increasing support from our profession as it grew in stature. In the endeavour to trace the origin of the term *weakfoot*, the catalogue of titles of The New York Academy of Medicine disclosed that Whitman was the author of a paper² which he read before the American Orthopaedic Association on September 18, 1895, in which he stated his position at the outset, as follows: "The type and

exemplification of the weak foot is the so-called flat-foot, ..." Amplification of this position is stated farther ahead in the paper: "The term weak foot has at least this advantage, that it implies nothing that the student must unlearn, for, if functional weakness is recognised, its causes may be analysed and appreciated; it is because of the misapplication and misapprehension of the term flat-foot, and because of the associations which which have so long obscured the rational treatment of the deformity, that the term has been discarded from the title of this paper."

Whitman introduced the term *weakfoot* in a paper published in 1892; although, according to his own statement, he had

(* Reprinted from Journal N. A. Ch. U.S.A.)

first become interested in the term in 1887. He used the term *flatfoot* exclusively in four independent papers published in four different medical journals between the years 1888 and 1893, with the exception of the 1892 paper, totalling five in all. Subsequently, three additional papers by him, on the theme of weakfoot, appeared between 1895 and 1913.

The 1892 paper represented a mild endeavour to propose the new term, not apparent in the title: "The radical cure of confirmed flat-foot."³ In this paper, Whitman took the plunge with his favourite term, *weakfoot*, when he inauspiciously announced his intention on the first page with this statement: "The term flat-foot is in some respects an unfortunate one, in that it does not correctly describe the affection . . . I propose, therefore, to call your attention to some of the predisposing and exciting causes of weakfoot, . . ." In this paper the term *flatfoot* is used preferably to designate *pes planus*, an inherited affection, or the result of *rhachitis* in infancy, and is used interchangeably with the designation *weakfoot*.

However, we consider the 1895 paper, referred to in the opening paragraph, a major effort to introduce the term *weakfoot* for general adoption. Thereafter, the influence of the new term gathered momentum in medical circles, and Whitman adopted it exclusively in the first edition of his textbook,¹ in which he states: "The term weak foot has this advantage over others that imply deformity, in that it may include the earliest indications of disability. Once weakness is recognised, its causes may be analysed and appreciated at their proper value. Flat foot is a particularly objectionable and misleading term, and it should be discarded, or at least used only to describe those cases to which it can properly be applied" (p. 533).

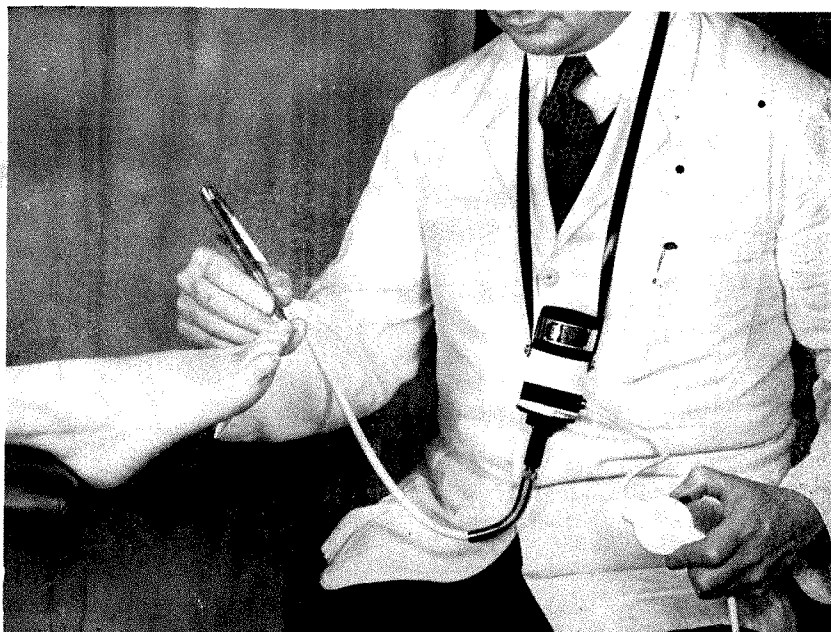
In the two following statements, Whitman stresses the importance of impaired

function rather than deformity:⁴ "Twenty years ago, when I first became interested in the weak foot as representing more particularly the less advanced type of deformity commonly called flat foot, . . ." (p. 1). He continues a few pages ahead: "From this standpoint, the popular term flat foot is so misleading and inadequate that it has been discarded for one that calls attention primarily to impaired ability rather than to deformity . . ." (p. 4). In a still later paper the same theme is again stressed, indicating that Whitman was pained by the general disregard of function or ability while great importance was attached to deformity, precisely what he fought against for many years:⁵ "I have used the term weak foot in place of flat foot, which is anatomically incorrect and which directs attention to deformity rather than to impaired function."

In connection with the foregoing statements by Whitman, there are two factors that deserve some notice here. First, the substitution of the term *weakfoot* for that of *flatfoot* failed to clear the therapeutic atmosphere after more than half a century, as Whitman had hoped in 1895. The "misapprehension" of the term *flatfoot*, to which he refers, had been aptly transmitted through heredity of ideas to that of *weakfoot* with the same deadly effect that prevailed when the term *flatfoot* was in vogue, indicating that "functional weakness" was not recognised, as he hoped also it would be. Second, he refers to weakfoot as a deformity, *secondary to functional ability*, meaning to describe it as such in the sense in which he deals with it in his textbook wherein he includes the milder types along with the most advanced. (cf., *Orthopaedic Surgery*, 6th ed., p. 665 et seq.).

But, as Whitman states, "if functional weakness is recognised," as we agree it should be, the term *weakfoot* becomes superfluous and even misleading when

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applied to a foot presenting the classical postural distortions so commonplace among large numbers of the population who never experience "functional weakness" in the course of a lifetime. On the contrary, as will be pointed out in this paper, individuals with weakfoot posture can exhibit functional stability far exceeding that of others whose foot-build is such that weakfoot (pronation) cannot develop due to uncommon morphological and architectural oddities, such as certain cavus types, yet who may be subject to functional weakness. Hence, the "ideal" foot exists as a figment of the imagination and, if perchance discovered, would not be immune to functional weakness.

An important contemporary of Whitman, and proponent of the weakfoot concept with certain modifications, was the late Otto F. Schuster,⁶ who followed in his illustrious predecessor's footsteps for a quarter of a century. He was the first member of our profession to accept and teach the concept many years before the publication of his textbook in 1927. He presented the concept in various papers, as well as teaching it throughout his career, from the time he became a member of the faculty of the New York School of Chiropractic shortly after its founding in 1911. He was responsible for making the concept stick in our profession through his capacity as Professor of Mechanical Orthopaedics, when the school later became known as The First Institute of Podiatry, and as Chief of Staff of The Foot Clinics of New York, where weakfoot was treated on the Whitman principle. In addition, he maintained a plant for the construction of the Whitman brace for weakfoot, the plate which became immortalised as a household by-word among orthopaedic surgeons and chiropodists of metropolitan New York and many distant points of the compass.

In those bygone days, original research

on the human foot was almost unheard of in our profession. But this did not, by any means, detract from the scholarly acumen possessed by the very few who, like Schuster, taught theory and practice with equal facility and showed the rank and file how to increase the limited scope of practice to which they were wedded.

It is apparent to the student of Schuster's textbook that the weakfoot concept was superficial to a deeper conviction when reference is made to the functionally impaired foot as of greater significance than the architecturally defective one. A telling statement is made on this point in the chapter on flatfoot:⁷ "In most instances, however, the degree of foot defectiveness is not judged as it should be by the extent to which a foot is functionally impaired; it is judged by its shape only." To this he adds:⁸ "It all depends upon the viewpoint of the examiner and his mode of judging a foot's efficiency, whether it is a first, second or third degree flatfoot. The one, judging a foot by its contour only, would not unlikely classify the racial congenitally low-arched foot of the negro as a third degree flatfoot—in other words, as a very defective foot, while the other, judging foot defectiveness by the degree of functional impairment, might consider it a normal foot, oddly shaped." On this point, a further doubt seems to occur in Schuster's mind in the definition of the term *weakfoot*⁹, the word being enclosed in double quotation marks.

Another timely statement on the ambiguous character of the term *weakfoot* is taken from Brachman:¹⁰ "Articles relating to 'weakfoot' notably go into great detail on objective and subjective symptoms, aetiology, pathology, symptomatology, diagnosis and treatment. So much material is covered that it is almost impossible to determine whether the condition is a true entity or whether a large

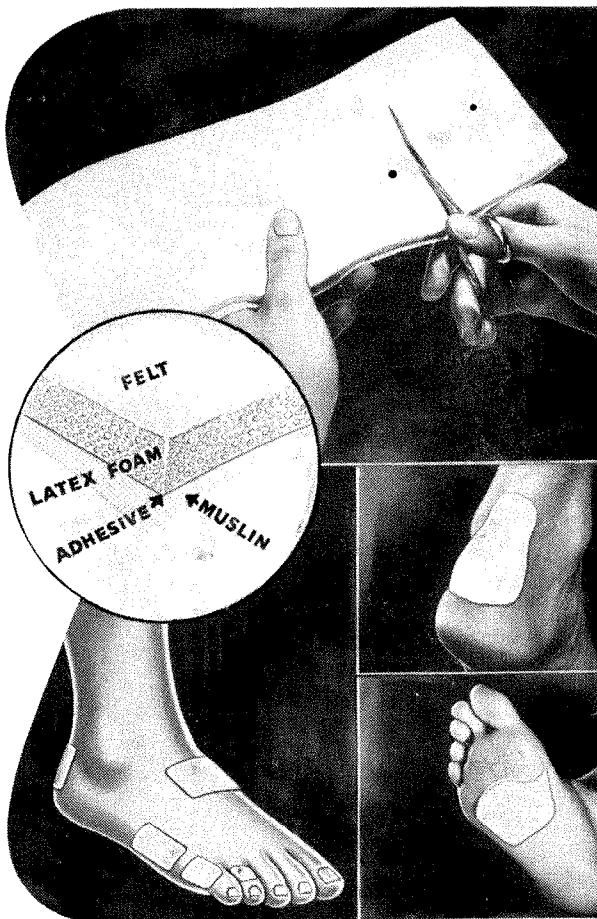
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number of foot conditions are being diagnosed and crowded under the blanket term of 'weakfoot.'"

In connection with the practical difference between a good foot and a bad foot, we present the following statements from Hiss:¹¹ "This book, based on a study of foot function, presents reasonable clinical proof that a foot may be greatly changed in physical structure, may be deformed, and have hypertrophic changes but still be comfortable. This comfort depends upon sufficient foot function to support the activity necessary each day."

The same theme comes up elsewhere in his book:¹² "Structural deformities and pathological changes in bone may often be misleading as to the ultimate comfort that may be obtained by the patient. Rather startling clinical examples, with X-rays, are given in this chapter—some with marked pathological changes from which the patient suffers no discomfort; and other contrasting cases, with no visible pathology, that have very painful symptoms in the feet and legs upon walking." Hiss's law states: "*Comfort Varies Directly with Function.*" (Op. cit.).

ARCHETYPAL STRUCTURE As pointed out on previous occasions, function (work) and structure (morphology) are not pathomechanically related in weakfoot. The point at issue is that diverse foot types are as commonplace as various body types, and in all cases may be regarded as normal to the individual if the odd shapes and contours do not interfere with optimum capacity to perform work without undue restrictions.

Furthermore, the weakfoot stance is exceedingly common at all age levels; in fact, more common than either the high-arched or other oddly-shaped foot types. The human foot is an archetypal structure, inherently capable of working naturally and efficiently, regardless of type of architectural build. The basic foot type

of the individual cannot be altered into any other type by ordinary mechanical means, short of surgery or foot-binding, with the possible exception of the infant's foot. Exceptions to this basic law are pathogenic changes brought about by bone disease or severe traumatic impact. The artificial life of civilisation has not changed the basic pattern of the human frame in any of its parts. Scientific excavations have brought to light civilisations going back into the night of time, showing that *homo sapiens*, from head to foot, remains fundamentally the same, even down to the crippling effects of some of the degenerative diseases known to-day.

One need not limit this comparison with contemporary races to learn that, as far back as before 13,000 B.C., the discovery of a footprint of prehistoric man¹³ gave evidence of a structure practically identical with that of modern ethnological characteristics. The similarity goes so far as to follow faithfully the gross contours and outline of the toes and the sole of the longitudinal segment as they are found in civilised man to-day. This footprint was discovered in a recess of the Grotto Aldene in Southern France by Norman Casteret, famous anthropologist and cave expert.

In the course of their investigations, anthropologists and paleontologists, who are *not indoctrinated with habitual forms of thinking in the realm of the scientific*, make interpretations of their findings of human or animal skeletal segments on the basis of possible function or specialised use of the parts. They consider the basic anatomic forms as expressions of the work for which the parts were designed. In like manner, the basic anatomic form of the human foot may be interpreted in terms of utility and adaptability, providing a diverse range of morphological and architectural expressions within the classification of normal.

(To be Continued)

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DANGERS OF COMPLACENCY

by G. Stanley Mercer

HOW easily the chiropodial profession is able to lull itself into an attitude of complacency. For a fleeting week or two the pronouncement of the official regulations governing the employment of chiropodists in the National Health Service excited some considerable interest, but that seems to have passed and we again slumber peacefully. This very same extraordinary attitude has, upon more than one occasion, been the cause of lost opportunities and stifled progress.

Within the profession itself there seems to prevail a belief that the new regulations mark the end of the Minister's interest in medical auxiliary healing. What a false belief this is. It is possibly only the beginning. Indeed the new regulations could be merely a prelude to far greater things to come.

Inadequate Training

The Minister's pronouncements, both inside and outside the House of Commons indicate quite clearly that he is seriously concerned about the loose way the medical auxiliary services are carrying on. Evidence collected by his department over the past few years has revealed the increasing number of people practising who have little or no training at all and have become a public danger. As the responsible Minister in the preservation of public health, he is in duty bound to tackle such dangers when they reach serious proportions.

Tight legislation is the weapon the Minister has at his disposal to end the menace. Who can doubt that he will use that weapon? And who can doubt that he will wish to consult with a respon-

sible representative body of each of the professions concerned?

There is no such responsible body which can speak for the chiropodial profession. Is there anyone from the top ranking chiropodial administrators to the humblest practitioner who still believes that the Minister will have any consultative dealings with a body representing only a minority of the profession? The negative answer to that simple question can be found in countless official pronouncements.

Breathing Space

I am not a lover of officialdom, but in this case the Minister of Health has been fair and tolerant. In effect he has given the auxiliary medical professions a breathing space to get their respective houses tidied up. Past events make it crystal clear that he is not the type of man to be toyed with. If in the course of time the professions concerned remain divided he will assuredly frame protective regulations without bothering to consult the different sections.

For unfortunate private reasons I have been rather out of touch with chiropodial happenings during the past week or so. I cannot therefore state with certainty that no progress has been made in the matter of consultative talks between the two chiropodial organisations which have now become qualifying bodies within the framework of the new Ministry of Health regulations. If progress has not been made, which of the two will take the initiative? The Joint Council may justifiably take the view that for the sake of its pride and dignity it cannot afford to make a further approach to the Society

after having suffered so many previous rebuffs.

• The First Move

The Society, however, in declining previous Joint Council overtures has upon each occasion safeguarded itself by stating that the "time is not opportune," or a meaning to that effect. Does the Society consider the time opportune *now*? It surely must. As I see it, therefore, the Society should make the first move in the direction of consultative talks with the Joint Council. I have no authority to assert that the Joint Council will respond but I am more than confident that it will, willingly.

If talks do open, however, I sincerely hope it will be behind locked doors. I suggest too that during the course of the talks both the relative journals will discreetly refrain from any reference to either

organisation, as one indiscreet word might easily wreck everything.

And so perhaps for the last time the future destiny of the profession lies in the hands of those entrusted with the policy and management of the two chiroprodial groups. I state emphatically that never again are they likely to be presented with such an opportunity. If it is ignored, as so many others have been, then those responsible will have much to answer for.

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Round and About



by "Vigilant"

OUR COMING OF AGE

ACCORDING TO MY records this journal soon celebrates its 21st anniversary. I understand the publishers are contemplating bringing out a special edition in June.

Except for a brief period during the war years, it has been my privilege to be closely associated with the *B.C.J.* in one way or another, the whole time.

I have seen many changes. Its policy has changed, also its make-up, but the Actinic Press Ltd., remain the only publishers.

A succession of well-known chiropodial personalities have occupied the editorial chair, commencing with the late Mr. John Bright. Although he was handicapped by indifferent health John's unbounded enthusiasm and journalistic flair brought immediate success to the journal. His was a job well done, but not always entirely appreciated.

The immediate post-war editor was that fiery, but most likeable personality, Franklin Charlesworth. Like his predecessors, Franklin's pet subject was the complete unification of the profession. In all his writings the theme of democracy was never absent. Time and time again he warned the profession where it was heading for. How right he turned out to be.

And so we come to our present editor, Mr. F. A. Drew. He is, perhaps, the

greatest advocate of professional unity ever to pen the editorials. In an indirect way I was largely responsible for securing his services. I believe that to be the one great deed I have accomplished for the benefit of the profession. Mr. Drew's editorials are eagerly read month by month by many thousands of his fellow practitioners. They have come to rely on his judgment. Although forceful and fearless in what he writes, he has the respect of most practitioners, whether they are Society or Joint Council members. That no doubt, explains the rapid increase in the journal's circulation.

How fitting it will be if during this anniversary year, the chiropodial profession becomes a closed one by means of State protection.

WHAT DOES IT MEAN?

I seldom care to quote passages from contemporary journals, but I am particularly impressed by the general theme of this month's editorial in the *Chiropodist*. For example, it states that "Much harm and loss of negotiating position can occur by a lack of unity amongst the professions." Does this denote a change of policy? Are we to understand by this that the Society are displaying a willingness to confer with the Joint Council? We shall soon know.

A LOAN

A CHIROPODIST acquaintance, who holds an appointment in the National Health

Service, complains that in framing employment regulations the Ministry of Health has put the cart before the horse. He contends that the Ministry's first obligation was to see that a thorough investigation be made into the disgraceful rates of remuneration offered to medical auxiliaries. He asks, how can a professional man keep up a decent appearance and live comfortably on £7-8 per week? I can't answer that one.

TIGHTER REGULATIONS

A TIGHTENING of the Ministry of Health regulations in regard to the supply of surgical hosiery may soon be expected, particularly in the official specification covering the various types and grades. At the moment the regulations are a little loose and leave open small loopholes for exploitation. I also understand that the Ministry's advisers have yet to be

convinced that nylon is necessary, or even advisable. According to my information, however, those who are regularly fitting surgical hosiery insist that nylon is not harmful to the skin.

IMPROVED PRACTICES

FOR THE MOST part chiropodists are reasonably busy. With the advent of less severe weather this is as it should be. One thing seems certain, however; chiropodists in private practice are holding their own very well indeed in spite of N.H.S. free treatment.

NO MORE VACANCIES

I'M TERRIBLY SORRY, but it is no use those in search of appointments or locum work, writing to me now. Those vacancies I referred to recently have all been filled. As soon as others come along I shall announce the details in this column.

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ABSTRACTS

From Our Contemporaries

Journal of N.A.Ch., (U.S.A.).

Effects of shoes on foot form

KNOWLES shows that the measurement of feet, training of shoe fitters, and use of X-ray equipment cannot compensate for the gross discrepancy between the triangular outline of the plantar aspect of the natural foot and the unrelated, pointed, tapering, or rounded outlines of modern shoes. The experiment described was based on the assumption that modern shoes distort the feet, and was designed to ascertain the reversibility of such distortion. Shoes of a suitable size were not made "to measure" or "to fit" in the conventional sense but rather to the shape and proportions that would fully accommodate natural feet. Special lasts had to be constructed, which were given a triangular plantar aspect. They were of suitable length and of average shape and width. Several pairs of shoes were made on these lasts and have been worn for three and a half years to the exclusion of all other shoes. X-ray photographs of the feet were taken on the day of the permanent change-over in August, 1948. By checking the external appearance of the feet against a photograph taken at the time of the change-over, it was noticed that no remarkable change occurred for many months. The wearer of these shoes was 37 years old, and rapid skeletal changes were therefore hardly to be expected. By November, 1950, however, some change was noted, and an X-ray picture was taken then showed that the toes had become less cramped. The experiment was concluded with final X-ray films taken in April, 1952. The valgus tendency of the hallux of the right foot was corrected. The left hallux, though it had less valgus tendency originally, has not improved so

much; the osteoarthritic changes in its metacarpo-phalangeal joint already shown in the earlier X-ray films are unaltered. Spread of the smaller toes has improved only to a slight extent. Excessive perspiration ceased immediately in the new shoes, the epidermophytosis eventually cleared spontaneously, and the onychocryptosis, though still present to a degree, ceased to be troublesome.

Med J. Austr., "Effects of Shoes on Foot Form: An Anatomical Experiment." F. W. Knowles.

The next extract should be read in conjunction with the following one taken from the Chiroprody Journal.

ANTIBIOTICS possess certain peculiar properties which differentiate them sharply from ordinary antiseptics and disinfectants. One of the most important properties of these agents is their selective action upon different cells, be they cells of microscopic life or cells of higher organisms. By forms utilizing this selective action, one can obtain antibiotics that are able, without injuring the tissues of a higher organism, to affect the pathogenic organisms invading such tissues. This makes possible their therapeutic use.

Ehrlich was the first to recognise that the efficacy of a chemotherapeutic agent depends upon the difference in its toxicity to the parasite and to the host. He was carried too far afield by his side-chain theory, and did not recognise clearly, largely because of a lack of sufficient information at that time, that this important difference in the action of a chemical compound is due to the variation in effect that it exerts upon the metabolism of the parasite as compared to that of the host cells. The compounds that he used were too "toxic," since they exerted their lethal effects upon the invading organism and upon the patient in about equal degrees. The finding of Woods and Fildes in 1940

that the sulfonamides exert their effect upon bacterial growth by interfering with the normal metabolism of the bacteria was a marked step forward in our understanding of the mechanisms of growth inhibition thus involved.

Selman A. Waksman, The Scientific Monthly 76:199, March 1953.

Chiropody Record, (Chicago).

DEVELOPMENT of the first "multibiotic," a combination of antibiotics able to kill or inhibit the full spectrum of harmful bacteria found in open skin wounds, was announced recently at a meeting at the New York Academy of Sciences. It was also revealed that the U.S. Food and Drug Administration has certified the "multibiotic" for sale without prescription, the first such approval given for antibiotics. The new development embraces a combination of streptomycin, bacitracin and polymyxin.

Dr. Clifford W. Price, a specialist in antibiotics research, explained that the need for such an agent as "multibiotic" was observed several years ago, after it was found that all known antibiotics were ineffective against one or more strains of harmful bacteria, and that in many cases bacteria developed resistance to antibiotics previously effective.

"An open wound of ordinary type," Dr. Price said, "may contain 23 recognised types of skin bacteria, as well as thousands of others not known. No single antibiotic will act against all of them."

Pakistani Medical Journal

X-RAY PICTURES without X-ray machines is a practical application of atomic energy, says the latest issue of the Journal of American dental association.

In the procedure a wooden stick coated with radioactive material is held against the jaw or tooth either inside or outside the mouth. This produces a picture on

a film held in the appropriate position. The new method has been reported by the dental scientists of the Ohio state university.

This could be useful also in chiropody.

Journal R.I.P.H.H., (London).

POLIOMYELITIS. This disease was more prevalent in 1952 than in 1951—3,902 cases against 2,609—but notifications were still substantially lower than the annual average since poliomyelitis became prominent five years ago. The case mortality again declined. Laborious investigation was slowly filling the gaps in our knowledge of the disease. On the prospects of immunization, it is mentioned that an efficient immunizing preparation against the poliomyelitis virus may emerge within the next few years.

LETTER

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal

FULL MARKS

SIR,—It is apparent that one can award full marks to the Editor of the *B.C.J.*, for his impartial and independent report on "the long awaited edict of the Minister of Health." My own personal interpretation of the situation fills me with considerable alarm and consternation. I must assume that both the Joint Council and the Society of Chiropodists will feel rather shaken, so I shall await their reports on the subject with apprehension.

One brighter outlook for me does emerge, if Mr. Mercer's remark is correct, namely, that "of . . . an abrupt end to isolationism." This attitude had so far defeated my attempts for a frank and friendly co-ordination of all concerned in the realm of chiropody in order to create an amalgamated and respected profession.

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NOTES AND NEWS

Schemes for the Aged

THE DIFFICULTY of transporting Bath old people, who are house-bound, to the chiropodists for treatment, was discussed at a recent meeting of the Mayor of Bath's Advisory Committee on Old People.

The suggestion that the city ambulances should be used was turned down by Mr. W. W. Evans, the committee secretary. In his opinion, the average consultants would not say that the cases were essential.

Mrs. E. Wyatt, secretary of the chiropody service, reported that 258 patients received attention in 1953 and there were 82 new patients. There was no waiting list at the moment, she added.

THE CHIROPODY SERVICE begun by Anglesey Rural Community Council for the aged of Menai Bridge is to be extended to Amlwch and Llangefni, and then to Holyhead.

A CHIROPODY SERVICE for old people of Cirencester has been started by the Old People's Welfare Association, available to all old age pensioners once a week. During this session of three hours seven patients can be treated. They pay 2s, each towards the cost of the treatment.

YARMOUTH AND GORLESTON Old People's Welfare Council is considering starting a chiropody service, and is including a sum of £50 in its estimates to provide for the cost of such a scheme.

OLD PEOPLE in Tottenham, London, would like to see chiropody treatment as part of the National Health Service. Cissbury Road branch are to submit a resolution suggesting this at the National Federation of Old Age Pensioners' Associa-

tions annual conference, to be held at Brighton in May.

IN THE ANNUAL REPORT of the Spennborough, Yorks., Old People's Welfare Committee, published recently, it was stated that a total of 283 old people were now attending the various chiropody clinics sponsored by that committee.

Free chiropody treatment is limited to those over 70 years of age.

AN OLD PEOPLE'S chiropody clinic has been opened in premises provided by the Salvation Army at Milton of Campsie, near Glasgow.

Research on Blood Flow

IN A RECENT SPEECH, to the Northampton Managers' and Foremen's Association, Mr. H. Bradley, director of research at the Shoe and Allied Trades Research Association, said that two orthopaedic specialists had been working for the research association for the past two years on vital research.

They were examining the flow of blood through the foot and considering the possibility that the feet acted as a kind of heart, a suggestion that was first put to him when he was in America three years ago. The new knowledge they gained might give footwear an increased importance.

Chiropody Service Refused

IN THE HOUSE OF COMMONS recently, Miss Alice Bacon, M.P. for Leeds North-East, asked the Minister of Health why he refused the request of the Leeds Health Committee to provide a chiropody service for old people.

Miss Pat Hornsby-Smith, parliamentary secretary to the Minister, in a written

reply, stated that the Minister regretted that he had to inform this and other local health authorities that financial considerations precluded any immediate extension of the limited chiropody service available under the National Health Service.

Nottingham Chiropody Service

THE NOTTINGHAM GENERAL Dispensary gave 54,000 chiropody treatments during 1953. This was announced at the annual meeting, held recently in Nottingham.

The dispensary, which is now in its 123rd year, employs 15 full-time chiropodists.

Athlete's Footwear

SIR ADOLPHE ABRAHAMS, when he opened the foot health exhibition at the Royal Sanitary Institute in London recently, urged research to produce a better running shoe.

He said, "In footwear the athlete is perhaps the worst of all sinners. To be a really fast runner on the track one has to wear a tight contraption which would be a permanent candidate for any museum of instruments of torture."

New Sussex J.C.C. Committee

MEMBERS of the Sussex branch of the Joint Council of Chiropodists at their annual meeting recently, appointed the following officers: chairman, Mr. E. Baker, of Worthing; secretary, Mr. W. F. Heasman, of Brighton; members of the committee, Mr. Basham, of Eastbourne, Mrs. Ford, of Hove, Mrs. Knowles, of Brighton and Mr. Finch, also of Brighton.

Private Practices Safe

THE FEARS of some chiropodists that if treatment was incorporated in the National Health Service their private practices would be affected, were allayed by Mr. J. H. Hanby, F.Ch.S., president of the Society of Chiropodists, speaking at the triennial dinner of the Leeds District branch, held recently in Leeds. "There is enough

chiropodial treatment waiting to be done in this country to keep both hospital and private practices busy for a generation," he said.

Professor R. E. Tunbridge, professor of medicine at Leeds University, paid tribute to the public spirit shown by members of the society in alleviating the foot trouble of the aged.

The chairman, Mr. F. H. Pateman, said that apart from their work for old people's hostels and hospitals they were attending to the children through the Leeds Education Committee and in many cases the most elementary treatment was saving serious trouble in later years.

Application for Licence

THE HEARING of an application by Mr. F. J. Kozler, for a licence to open a chiropody and massage establishment in North Kensington, London, was adjourned sine die at London County Hall, recently.

Mr. R. J. B. McDowell, chief officer for the London County Council public control department, and a witness for the council, said that Mr. Kozler had said he would be at the hearing, but had not arrived. Mr. Kozler had said he had received training in Czechoslovakia and had had a practice in Paris, but these statements could not be verified.

The chairman accordingly adjourned the proceedings.

Chiropody for Every School

THE OPINION that chiropody should be in every school in Lancashire where the need was found, was expressed at a recent meeting of the Lancashire Education Committee in Preston, by Councillor J. Hargreaves.

He was glad to see that a chiropody service had been recommended for one school in the county, and he hoped others would not be left out for long.

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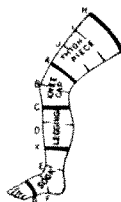
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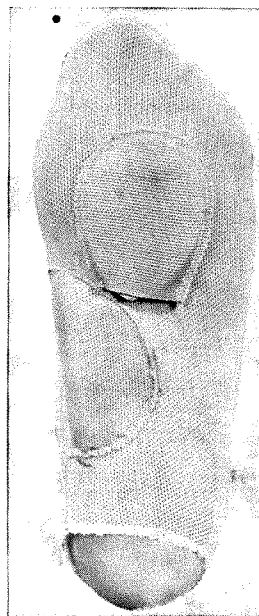
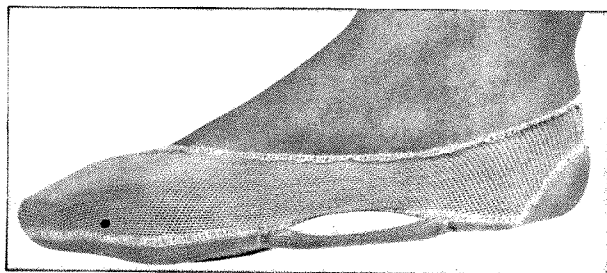
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Vol. 19. No. 4. April, 1954

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CIRCUMSTANCES DICTATE We are passing through a crisis in chiropodial history and the Minister of Health has had to take decisions in matters with which he would have preferred not to concern himself, viz., standards of professional training and practice. His work would have been so much simpler if he had had to deal with a unified and solidly organised profession with nationally agreed standards of training and practice, and he would have been spared the thankless task of endeavouring to sort out the sheep from the goats had all isolationist policies been abandoned long ago and the profession prepared for national legislation independently of the other auxiliary medical bodies.

The situation which confronted the M.O.H. was that not only were there numerous auxiliary medical bodies to be sorted out, but so far as chiropody goes, this was in a state of confusion, with the two principal bodies unable to agree even to talk about a common policy. As the Cope report showed, there are smaller bodies also which hope for equality of consideration, and un-noted officially there is a large and increasing body of correspondence-trained persons entering the practical field whilst the leading organisations affect to ignore them as if non-

existent or at least quite unworthy of notice.

The M.O.H. has done what he could with a deplorable situation, with the sole idea of seeing that only those who are able to comply with his requirements will find their way into the National Health Service. The treatment and cure of all the ills from which chiropody suffers are not his immediate concern, although he may be aiding the first step to a change of ideas by forcing the Society and the J.C.C. to a measure of consultation and mutual respect.

WE MUST BE REALISTIC The requirements of the M.O.H. in matters of chiropody are small, and many of the practitioners thus employed are engaged for part-time periods. Thus the present action of the Minister does little or nothing to solve the vital problems of chiropodial practice in this country. As we have previously stated, we cannot imagine that chiropody will ever be included as a nation-wide free-for-all benefit under the N.H.S. Indeed, it is our opinion that such a service would be utterly financially foolish. From the point of view of the profession as a whole the vital question is not who should be eligible for employment under the N.H.S., but rather,

who ought to be allowed to practice chiropody in Great Britain. However, if the profession has no one voice to speak for it as a whole, then one can understand that the Minister is obliged to take such steps as may ensure the smooth working of his department. At the same time he noted that he has expressed the hope that as soon as possible he should not have to concern himself with these professional standards, adding that some bodies had obvious affinities and might eventually come together and achieve statutory registration.

The Minister should be thanked for those words; they are a pointer in the direction in which the signpost of this journal has stood for years.

REGISTRATION SUPPORTED In the course of the House of Commons debate Mr. Somerville Hastings (Barking) suggested that chiropodists and physiotherapists should be registered as for state registered nurses, and that legislation should be prepared for registration and proper training in future of these two bodies. He added that as their qualifications and duties became more definite they also, he believed, would rank for registration by special legislation.

Further support was forthcoming from Sir Hugh Linstead (Putney) who made a plea for registration by statute, saying that with goodwill it should be possible to draft a Bill which could reach the statute book through the private members' procedure.

In his reply the M.O.H. indicated that he could not say how long his proposed working party would need to produce results, and added that for 18 months the different bodies and his department had "mulled over the Cope Report without results."

SAVE OURSELVES It must be concluded, as we have indicated on a number of occasions, that the inspiration and

power to save chiropody as a worthy profession must be found within ourselves. Within ourselves must be found that spirit of tolerance, wisdom and understanding co-operation which will draw all bona-fide, conscientious, chiropodists together, and without sacrificing attained standards of ethics, training and practice, thrash out the basis for an organised profession worthy to be the subject of legislation under the protection of which it may aspire to healthy growth and development.

Refusals to talk with our neighbours in the profession will lead, and has led, us nowhere. Our problems extend beyond the confines of any one society: all are affected and the help and co-operation of all are needed to create in this beloved country of ours a real National Association of Chiropodists and, with its formation, to close the door to those who in future cannot fulfil the legal conditions of practice.

Equality of Opportunity

IN LAST MONTH'S Editorial part of the second paragraph on page 62 was inadvertently omitted. It read:

Equality of treatment does not always produce equality of results and the equality accorded to the two bodies is not in the nature of an equality of opportunity of proving their merits.

It should have read:

Equality of treatment does not always produce equality of results and the equality accorded to the two bodies is not in the nature of *an equal award of prizes, but rather in the nature of* an equality of opportunity of proving their merits.

The Editor particularly wished to stress the importance of the fact that the two bodies now had an equal opportunity of proving their merits, and it is regretted that by the omission of these words his meaning was obscured.

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ARCH SUPPORTS AND THEIR USES

By R. D. Calver, M.Ch.S. and G. J. Tong, M.Ch.S.

WE feel that in those cases where supports are considered advisable as an aid to treatment, the ideal would be for all of them to be made or fitted individually for each patient, whether by plaster cast or any other means.

Leather and rubber. This is probably the most popular type of support in use to-day and incorporates either a metatarsal cushion or valgus pad, or a combination of the two. The leather and rubber is usually of the softest variety, thereby affording the maximum cushioning effect, particularly to the arthritic and elderly type of patient.

Leather and metal or all-metal. The properties of the metal employed in this type of support are strength and flexibility, strength to be able to support the heaviest patient and yet flexible enough to control excess movement within the foot, whilst allowing the natural movements to still take place. By the use of different metals varying degrees of flexibility can be achieved in the support and the metal should be chosen with regard to the occupation and weight, etc., of the patient. Some people have a mistaken idea that a support which is entirely or partly composed of metal must have a splinting action on the foot. This is not so however, as the flexibility of the metal follows the natural elongation of the foot, but prevents excess elongation which is present in the weak foot, and corrects the associated faulty foot posture.

The metal or leather and metal support conforms in shape to the insole of the shoe up to the metatarsal heads and in addition to relieving general foot weakness may have a metatarsal dome or valgus elevation if it is designed to relieve

foot conditions related to these areas. An all-metal support is fitted sometimes in preference to a leather and metal support, as it is more impervious to the sweat from a hyperhidrotic foot than a leather covered support and it supplies more correction to the foot and allows a greater degree of adjustment. In addition it takes up less room in the shoes than a leather covered support, an important consideration for some patients.

The metal, or leather and metal, support by virtue of its flexibility is therefore adjustable and the elevation of both the longitudinal arching of the support and the metatarsal dome, can be altered to suit the degree of weakness in the foot, the amount of correction required, and the comfort of the patient. All this is most important and should be checked at regular intervals to ensure that the patient is deriving maximum benefit from the support. It is obvious that this type of support possesses advantages in this respect over the orthodox leather and rubber support. In addition, as the metal type of support deals effectively with excessive elongation of the foot the patient finds that there is more room in the toe box of the shoe, thus avoiding cramping of the toes and the resultant digital lesions which so often bring patients to us for treatment.

FOOT CONDITIONS *Weak foot.* By this term we mean a foot in which muscular tone and action are diminished, so that normal function is impaired and excessive strain is thrown upon the ligaments. These factors give rise to pathological conditions known as foot strain, and valgus foot.

The first consideration is to relieve the painful condition and to prevent the foot from becoming further weakened. The use of a leather and rubber, leather and metal, or all metal support realigns the foot into its natural position and allows the muscle tendons to act in their normal position and therefore at their optimum efficiency.

The second consideration is the correction if possible, of the weak foot condition. As the use of well fitting support provides relief from pain and a better functioning of the muscles, the continued use allows these muscles to gradually regain their original tone and power and should give a natural correction to the condition. It should also be possible for the patient to dispense with the support as and when desired, with the resumption to continuous use, should the condition deteriorate or pain recommence. Many patients state however, that maximum benefit is obtained by the continuous use of the support, even after the original condition has been relieved or if possible, corrected.

Metatarsalgia. This term usually implies pain in the forefoot, chiefly in the region of the second, third and fourth metatarsal heads. The general object of treatment is to provide an elevation directly behind these metatarsal heads, thus relieving the pressure in this area, and, as overloading of the metatarsal heads is a prominent feature of this condition, a more even distribution of weight over all the metatarsal heads is achieved. A support incorporating a metatarsal dome, in the case of a leather and metal, or all metal support, or cushion in a leather and rubber support, besides relieving pressure in this way also encourages the toes to straighten and play their part in the natural functions of standing and walking.

Pes cavus. This condition, in which the

longitudinal arches are accentuated may be either flaccid or rigid, the latter type being the most common.

In the flaccid type, the application of a support, will control the tendency of the foot to roll into a valgus position, due to the instability of the inner border, thereby relieving the accompanying muscular and ligamentous strain.

The rigid type of pes cavus, on the other hand, has very little capability of movement, owing to the taut nature of the ligaments, plantar fascia, and the muscle tendons which control the foot. Consequently, the natural inclination of the foot to lengthen and broaden on weight bearing imposes a strain on the already taut structures, giving rise to metatarsalgia, and pain in the longitudinal arches and in the calf.

The application of a well-fitting support, whilst not correcting the rigidity, serves to limit the tendency to movement within the foot which gives rise to pain in the long arch, to distribute the load being thrust upon the metatarsal heads, and to correct the faulty foot posture which is so characteristic of this condition.

MISCELLANEOUS CONDITIONS *Hallux valgus.* Among the many theories for the causation of this troublesome condition is that of excessive elongation of the inner segment of the foot. Effective control of this, can do much to relieve the tendency towards hallux valgus.

Mortons' syndrome. For those patients in whom this condition has been caused by a nerve impingement, it has been found that a metatarsal dome in a leather and metal, or all metal support, in the region of the third and fourth metatarsal heads, has given relief from pain, by the elevation of these metatarsal heads.

Elderly patients. Whilst this is not really an appropriate title for a condition, the elderly patient presents a problem

which is quite individual, the lack of fibro-fatty padding in the foot causing discomfort even if there are no corns or callouses. The obvious method of treatment of these folk is to provide them with that comfortable padding which they have lost and the use of a soft rubber and leather support can do much to alleviate this condition.

Likewise with the arthritic type of patient where, due to the periarticular inflammatory nature of their joints, every step is painful, the soft cushioning effect provided by such a support will greatly

relieve their discomfort.

CONDITIONS Whilst we would stress that we do not consider that all foot conditions can be treated by the use of supports, we feel that in dealing with patients the support is worthy of careful consideration as an aid to treatment. In addition, of course, advice should be given regarding footwear, physiotherapy, etc.

We hope that these few comments may stimulate some interest and will help members to take a broad view of the whole subject of arch supports.

CHIROPODIAL ADVANCEMENT

A Graduate's View

by M. J. W. Yeomans, M.Ch.S.

CHIROPODY is still an undeveloped branch of the senior profession of medicine, and from the academical point of view, as compared with the professions of law and divinity and spheres of learning in the arts and sciences in which university degrees are awarded, it has far to go. But the extension of the Society's curriculum to three years in September, 1953, was a step in the right direction as far as the educational side of the chiropodial profession is concerned.

The establishment, too, of a recognised entrance examination, such as the General Certificate of Education examination with special compulsory subjects at either the ordinary or advance levels, is a sound basis for educational advancement, for of course, the ultimate aim must be to place the qualifying diploma in chiropody on a level at least comparable with a graduate's of British universities.

Chiropody as a branch of the healing art needs a curriculum embracing certain definite subjects, and a standard of knowledge of these subjects well above the

level required for the practical coverage of the chiropodist's day to day work.

I would suggest that compulsory subjects in the entrance examination be such as are considered desirable in the pre-medical studies of medical students, viz., chemistry, physics, biology or alternatively, where biology is not offered, zoology and botany.

If these three subjects were made faculty requirements for admission to the Society's curriculum, a saving of months of study in the course would be effected. Such a saving in time would then be utilised in further study of purely medical and chiropodial subjects.

It is desirable that a series of lectures and demonstrations embracing the chiropodial aspect of the technique of diagnosis should be incorporated in the professional curriculum, a part of which I feel could still be extended. A set syllabus, in place of the present individual reading, for the post-graduate diploma of Fellow of the Society of Chiropodists would also be welcomed on the lines of the post-graduate

diplomas and degrees in medicine.

With a view to building up and consolidating the status of the chiropodist, and improving the background of the profession as a whole, it would be in the Society's interest to grant annual awards to graduates of British universities in the arts, sciences and laws, amounting to the whole of tuition fees, books and instruments for the necessary course.

Naturally, some opposition can be anticipated from members who will suggest that university graduates would not wish to study for a chiropodial career after spending a number of years at a university.

I cannot agree with this view, for it is a fact that quite a number of graduates who do not use their specific academical knowledge gained at university for their ultimate everyday occupation do most certainly regard their university training as an essential background to their future life.

For the betterment of our profession, therefore, in its ultimate goal towards state registration and general increment of status in the eyes of the authorities and the general public, a gradually increasing nucleus of members who have had a university training would be ensured.

All professional bodies, whether they be medicine, law, divinity, pharmacy, or the teaching professions, and all trades and crafts who are endowed with public responsibility should have members repre-

senting them in Parliament. To take one instance, the secretary of the British Pharmaceutical Society, who has been a member of Parliament for a number of years, puts his society's case in the House whenever the occasion warrants it. How stronger would the chiropodial profession have been had it also had representatives in the House?

Older chiropodists may think that my views are too ambitious, but let me add there is plenty of time to hasten slowly to the ultimate object. If the ultimate object of the profession is to elevate the qualifications and status of its members to that of university graduates, then the appropriate academical background must be built up and maintained. Should the profession hope to emulate the professions of medicine and law in their service to the community, then they must also be willing to share in the leadership of the nation in the high administrative places of the country.

Each member who reaches distinction in public life reflects that distinction on the profession as a whole.

We cannot remain static as a Society or a profession; we must go forward or go back. The advancement of the chiropodial profession as a national body depends upon the future members as well as on existing practitioners. It is to the future we must look and to future chiropodists, and plans must be made now.

THE WEAKFOOT CONCEPT* —Part II

by *L. F. Schreiber, F.A.A.C. (Hon.), F.A.C.F.O., and
H. W. Weinerman, D.S.C.*

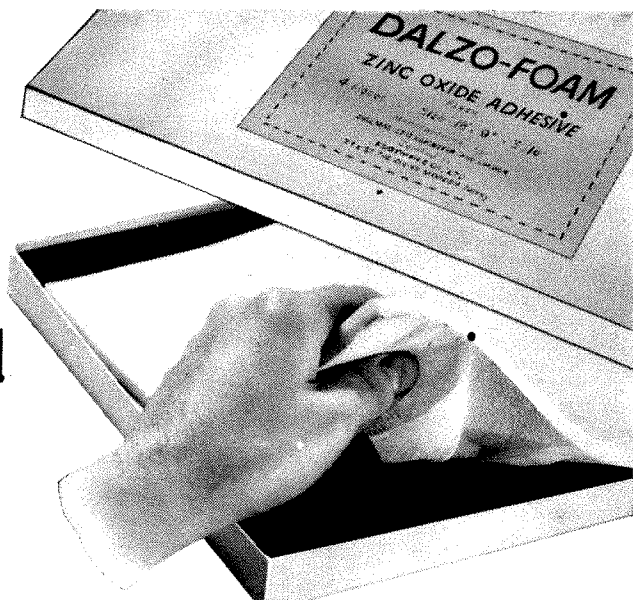
HISTOGENESIS AND MORPHOGENESIS

In setting the stage for critical evaluation of the weakfoot concept, this paper requires preliminary consideration of histologic factors involved in the law of adaptation of structures to the

requirements of function or work. In this connection it is well to recall that, governed by physiologic and biologic laws, all tissues undergoing morphologic transformation begin this process from centre to periphery of the cell, working from within-without of the gross anatomy

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locally involved. This process makes its presence known outwardly or morphologically only after the inner histologic changes take place. It is at this stage of the process that various physiologic laws, such as Wolff's law and Davis's law, are said to manifest in such parts, the evidence being more or less objective to the eye.

At this point it is essential to emphasise the fact that neither the architectural build nor the morphologic appearance of the foot is in any way involved in the gross production of the so-called weakfoot posture arising out of histogenesis and morphogenesis inducing changes brought about by either dysfunction or new functional demands of any nature. To assume otherwise would mean the violation of a basic anatomic consideration to the effect that a foot which since early life showed no tendency toward the development of weakfoot posture could transform itself from its original architectural build into that of another type entirely dissimilar in character. To state this position in another way, the cavas type of architecture can no more transform itself through faulty function into the weakfoot type than the body build of an individual can transform itself from the short, squatty frame into the tall, spare type.

Histogenesis embraces three major types of germinal cells under Wolff's law and Davis's law:

- (1) Osteoblasts (bone tissue)
- (2) Myoblasts (muscle fibres)
- (3) Fibroblasts (ligaments, fasciae, tendons)

In the restricted sense, as applied to physiologic laws, histogenesis means the part played by the germinal cells of the tissues involved in bringing about changes in the local morphology of any structure, depending upon functional demands. In this connection, there are three distinct classes of histogenetic changes: (1) normal, (2) traumatic, (3) pathogenic.

In the same restricted sense, morphogenesis means any change or deviation of the gross form or shape of localised structures induced by histogenesis, from within-without. Thus, osseous structures, soft tissues, and all organs of the body develop or retrogress in accordance with the law of tissue transformation. The best example of this law may be found in the myogenetic power inherent in striated or striped muscle fibres, highly responsive to all extrinsic and intrinsic stimuli, operating through the germinal cells.

As a result of this innate power of transformation, all anatomic morphologic changes are the direct effects of histogenesis and morphogenesis. Such gross changes are not *pathogenic processes* in themselves, but are simply the result of the operation of histogenesis under *functional or pathologic requirements* occurring in the physical economy, resulting in precise mathematical anatomic effects.

Gross pathology or disease, deformity and trauma, deal with the restricted function of the part according to the state of the structures, but never with the structures apart from the work they are capable of performing. The physiologic laws underlying any state do not deal with gross changes of any kind. Structural changes deal with the internal architectural design created by the germinal cells. Freiberg¹⁴ states that a deformity in this sense is non-pathologic and is simply the result of altered static requirements, whatever the primary cause may be.

From this analysis of the relationship of function and structure, based on histogenesis and morphogenesis, it may be stated that there are four distinct steps involved in bringing about changes in the structures, based on Wolff's and Davis's Laws:

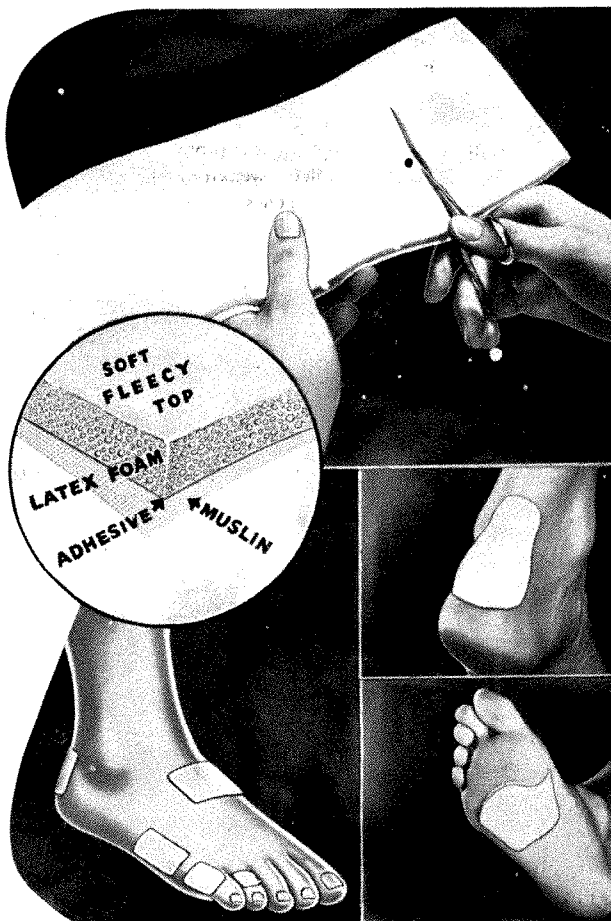
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by germinal cells

4. Gross anatomic result (morphological changes)

DAVIS'S LAW OF FUNCTION AND STRUCTURE. Concerning functional adaptation, as described by Davis in his monograph, several passages are abstracted from an exposition in that work,¹⁵ elucidating his statement associated with the familiar wording of Davis's law. These abstracts show the relation of the universal laws of tissue-structure changes as applicable to the foot. Such functional changes produce the distortions and deformities commonly found in the routine practice of chiropody, those of the forefoot and the phalanges being the most common.

But the rearfoot is not nearly as vulnerable to such distortions as is generally implied when the term *weakfoot* is applied in that sense. The rearfoot is firmly braced by a quaternary of bones—the malleolar articulations of the tibia and fibula from above, and the vice-like grip of the mortise formed with the talus from below—the subtalar articulation being firmly planted on the calcaneum or fulcrum.

In discoursing on scoliosis, Davis states:

"The testimony drawn from the condition of the bones, cartilages and ligaments, after a curvature has existed for years, as proving the cause of the deformity, is perfectly fallacious, for the reason that the same result will take place in any other joint, when retained for the same length of time in the same abnormal position. The condition is the *result* of the curvature and *not the cause*. The bones and cartilages will be absorbed by *unremitting pressure*, the ligaments will be *actually lengthened* by *unremitting tension*, those that are *relaxed uninterruptedly* will *not* be renewed any longer than the distance between their points of origin and insertion. *These laws of the animal economy, therefore, can be relied upon; they ought to govern us in considering the condition*

of joints and parts that have long been in an abnormal position."¹⁵

"...by means of the principle we have promulgated, that a ligament or other soft tissue, can be elongated to any desirable extent by the use of *continued elastic extension*, we have it within our power to reduce almost any dislocation, without reference to the length of time it has been luxated, but it can be done, not only without pain or suffering, but without the slightest danger to life, and with almost a certainty of a perfect restoration of the joints to all its functions."¹⁶

"We have long noted as a fact that, if a part be placed in an unnatural position, and retained there for a long time, the patient loses the power of volition after a while, in consequence of the brain ceasing to exercise its will over the particular muscles involved, and as a consequence of this neglect of volition, and want of exercise, the muscles themselves lapse into a state of atony, and eventual inability to respond to the will, which is equivalent to paralysis¹⁷."

"If the reader will turn to page 139, . . . he will find, instead of theories, physiological facts that are incontrovertible—the same results following the conditions there laid down have never failed in our experience of twenty years . . . Much of this reasoning, from the appearance of parts that have long been in a changed position, is fallacious; in a large number of cases the appearance is the result of the changed position, and not the cause¹⁸."

The above reference to page 139, on physiological facts, contains the original statement by that author, which has become known as Davis's law. In principle, Davis's law agrees perfectly with Wolff's law; in other words, the law of soft tissue transformation (Davis's law) is identical in physiological principle with the law of bone transformation (Wolff's law). It is noteworthy to recall that Davis's law (1867) antedated Wolff's law (1892) by twenty-five years.

(To be continued)

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TWO PROBLEMS

by G. Stanley Mercer

THIS month I want to deal with two subjects, each of which is far removed from the other.

The first is a matter of principle and concerns the formation of one or two new chiropodial organisations. It seems that these new groups are sponsored by ex-members of one of the established organisations who have become dissatisfied with the way chiropodial affairs are being conducted.

I do not question the sincerity of purpose behind these new formations or the organising ability of their sponsors. But I do question the wisdom of the ventures. In present delicate circumstances what really useful purpose can they possibly serve?

Those at the helm of these ventures must surely realise that whether the chiropodial profession likes it or not it is now in the firm grip of officialdom. The Minister of Health has by his many pronouncements made it perfectly clear that he intends to regulate the practice of all medical auxiliary work, which, of course includes the practice of chiropody. He has already given a measure of recognition to the two major organisations and made it known that he has no interest in others that are or those to be.

What chance of survival then has any new groups? Can it hope to get far without the official label of recognition? It may be that the leaders of these new rebellious groups consider themselves sufficiently powerful to resist the entry of officialdom into the profession. If that is the trend of their thoughts, they might just as well try pushing down a hefty brick wall with a feather.

There are many hundreds, perhaps thousands, of chiropodists who are dis-

satisfied with the conduct of affairs, but most of them realise that the formation of break-away organisations offers no solution to the problem; indeed it can only aggravate it. The real solution lies in the constitutional right of every member to voice his dissatisfaction.

I freely admit that most dissatisfied members are rather timid and seem to lack the courage of expression. Maybe they are overawed by atmosphere at meetings, or fail under the dictatorial personality of others. Nevertheless, there *is* a constitutional remedy, and if members fail to use it they have only themselves to blame.

The other subject I want to deal with concerns those chiropodists who are supplying surgical hosiery to N.H.S. patients on form E.C. 10. The Ministry of Health has dipped into their incomes in a big and outrageous way. Until now suppliers were allowed a 50 per cent profit margin on the manufacturer's basic prices, plus one penny on each prescription. Now, however, the basic profit margin has been slashed in half, to 25 per cent and to soften the blow a little the prescription fee is increased to 3s. 6d.

And so the Ministry has imposed economies in every branch of the surgical hosiery industry out of all common sense proportions. The manufacturers have to work to a basic figure dictated by the Ministry which I am told leaves a rate of profit hardly workable. That in turn means that the wholesale distributors are similarly affected and now the chiropodist is required to sacrifice a big slice of his profit. Protests have, of course, been made to the Ministry, but there is no one representative protective organisation to fight effectively.

According to my information, neither of the chiropodial organisations have moved in the matter at all. They may, of course, consider that surgical hosiery is outside the chiropodial field and any interference on their part is unwise. Against this contention, however, I suggest that as the Ministry of Health agrees that chiropodists are fit and proper people to fit surgical hosiery, their respective organisations should watch their interests, particularly when incomes are involved.

The whole set of circumstances surrounding the supply of surgical hosiery under the National Health Service needs careful official investigation. There is a background which is not to the liking of those concerned in the industry. Already some embarrassing questions have been asked in the House of Commons and in one instance an incorrect reply was given. It may well be that a deputation

of the industry will meet the Minister and get the matter cleared up.

As in the case of the chiropodial profession, the surgical hosiery trade is not united. Had it been, the present unsatisfactory state of affairs would certainly have been avoided. However, influences are being brought to bear which may bear fruit.

I am in close touch with events and if in my small way I can do anything to obtain fairer prices for chiropodists I shall certainly do my best. In the meantime, every chiropodial supplier should make his feelings of disapproval known to the Ministry. And if either of the chiropodial organisations feel disposed to take the matter up on behalf of their members, I shall be happy to provide them with information which it would not be prudent to give here.

THE
Australasian Chiropodist

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The Society of Chiropodists

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Round and About



by "Vigilant"

MR. F. PARKIN

I LEARN WITH THE deepest sorrow the
ing of Mr. F. Parkin of Stockport.
h not particularly well-known to
nger school of chiropodists, Mr.
was a pioneer. Unassuming and
mannered he nevertheless had the
onvincing others of his own beliefs.
here the war I regularly enjoyed the
advantage of his kind hospitality.

NO SENSE OF VALUE

EVERY CHIROPODIST is proud in his
boast that his practice is a very personal
affair, but if he should want to sell it he
often conveniently forgets how very per-
sonal it is and prices it far too high to be
of value to a newcomer. One very old
established practice is for sale at a most
fabulous price. I declined to recommend
it to a prospective purchaser at the price,
and of course offended my very old friend.

A SERIOUS LOSS OF PROFIT

SINCE APRIL 1 thousands of chiropodists
have suffered a serious loss of income.
The Ministry of Health has cut the profit
margin on surgical hosiery to an alarming
extent. The subject is dealt with in detail
elsewhere in this issue. I would, however,
like to comment that in this matter the

Ministry has been grossly unfair. For
example, the chiropodist supplier of sur-
gical hosiery spends at least 20-25 minutes
in careful measurement and fitting, but
is permitted only the same profit margin as
the retail chemist who sells elastic hosiery
over his counter rather like a bottle of
salts. There is something radically wrong
with this strange system.

JOINT COUNCIL A.D.C.

THE ANNUAL DELEGATES Conference
of the Joint Council of Chiropodists will
be held at Bournemouth on Saturday and
Sunday, May 1-2. A Dinner-Dance will
be held on the Saturday, but this is not
otherwise a social or educational occa-
sion. It is strictly a business gathering
when policy is determined and matters
of major importance dealt with. This is
one part of the Joint Council constitution
I like very much. By its means individual
members, through their branch repre-
sentatives, are in close contact with those
entrusted with the top management of
the organisation. As a result of recent
events I rather imagine the delegates will
once again be in good mood.

Whilst writing of Joint Council matters
the office of Secretary is in the hands of
Mr. S. G. Shipper for the time being.
Mr. V. T. Semmens is acting as Chairman
of the Executive Committee.

HIS DILEMMA

FOR MORE THAN THREE YEARS a young
chiropodist struggled unsuccessfully to

establish a private practice in a quiet residential road. He failed, so he says, because he is denied the opportunity of making his presence effectively known. He has now obtained the offer of an attractive appointment with a commercial concern. But the firm insist that the fullest publicity be given to their chiropody treatment section, including a window display. My chiropodist friend has forbidden the use of his name, but remains anxious, wondering if his organisation will pounce upon him on a charge of a breach of ethics. For reasons of self-preservation more and more practitioners are being forced into the commercial field as employed people. I have, I hope, given sound advice to my young friend.

CONVENTION

THE SOCIETY of Chiropodists Annual Convention will this year, be held at the Central Hotel, Glasgow, during the three days, September 9,10 and 11.

The programme follows the usual Convention pattern, but this particular Convention should prove highly attractive as the Scots are splendid organisers and possess the blessed gift of grand hospitality.

THE BUSINESS BAROMETER RISING

AS IS USUAL in the Easter period, practices report a marked improvement. Patients, however, are not inclined to spend more than is absolutely necessary.

A MEMBERSHIP OFFER

A CHIROPODIST friend who has a very busy practice in an inland Kentish town wants to ease up a little and is looking for a partner. The offer is particularly attractive because it does not involve the requirement of a capital sum. He other plans to offset that. His preference is for a male of experience who is a member of the Society. I addressed to me in this connection forwarded on.

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ABSTRACTS

From Our Contemporaries

Journal of N.A.Ch., (U.S.A.)

HYPERHIDROSIS of the hands and feet usually abates after application of constant current. The effect which is temporary, apparently results from direct inhibition of the sweat glands. Metal electrodes, preferably aluminium plates, heavily covered with cellucotton, are laid in two enamelled or plastic photographic trays and tap water is added to cover the hand resting comfortably on the electrode. During the first few treatments, the fingers and all palmar cracks and fissures may have to be coated with cold cream or petroleum jelly to prevent pain. The current intensity, sometimes of 50 to 75 milliamperes, depends on the tolerance of the patient and is applied for twenty to thirty minutes daily or every other day until the condition disappears. In treating the feet, earthen crocks may be used as the containers. All usual precautions must be observed against sudden interruption of the flow. H. D. Bouman, M.D., and Emma M. Grunewald Lentzer, M.S., of the University of Wisconsin, Madison, report success in 103 of 113 cases. Drying was effected in 6 additional patients with aluminium ion transfer. Remissions after five to thirteen visits last as long as three months and patients usually willingly return for re-treatment. *Am. J. Phys. Med.* 31:158-168, 1952.

VARICOSE VEINS form part of a hereditary syndrome of generalised fascial weakness. The tendency toward the regrowth of varicose veins is inborn and cannot be eliminated by any known method of treatment. Not a single permanent cure has been secured by either surgical-

treatment or injection, or by any combination of these methods, in the experience of 20 years. Many reports of favourable results are based on an insufficient follow-up; recurrences have sometimes been observed as long as eight years or more after apparently successful treatment. Lymphedema is a frequent complication of vein surgery and should be studied more carefully; if lymphedema is found to occur in a significant proportion of cases, it will be necessary to conclude that surgical treatment of varicosities is inadvisable. The venous circulation is abundantly supplied with secondary channels and this safety factor, which protects the body in the event of trauma, works against any successful treatment of varicose veins; the reaction produced by therapy aimed at their elimination is the same as that produced by injury. Communicating and anastomotic changes immediately begin, and fresh varicosities may appear in the newly developed secondary circulation. Conservative treatment by sclerotherapy remains the treatment of choice, but since the condition is chronic, it can only be held in check by periodic examinations and supplementary injections as needed. No patient should ever be discharged as cured.

N.Y. State J.M., April 15, 1953.

FLATFOOT deformity in children is due to a muscle imbalance. The muscles on the lateral side of the foot work at an advantage and pull the foot into a flatfoot position. Mild cases may be treated by swung-in shoes alone. The more severe flat feet need manual stretchings in addition to swung-in shoes. Older children are taught exercises, as follows: The patient in sitting position is taught how to turn the foot down and in and up, pulling it up with the anterior tibial muscle, and holding it for the count of ten. This is repeated a given number of times. In standing

position, he is taught to stand pigeon-toed and to come up on the tiptoes and hold it for an instant and return. This is done a given number of times. Still standing pigeon-toed, the patient is next taught to come up on the lateral border of the feet and to hold it for an instant, doing this the same number of times. If the heel cords are short, a fourth exercise is taught. The patient stands near a wall and leans forward and touches his chest to the wall. He must stand pigeon-toed and must keep his heels tight on the floor. More stretch can be put on the Achilles tendon by standing a little farther from the wall. Arch supports are used only occasionally for the more severely deformed feet. Satisfactory results may be expected if the treatment is begun early and followed persistently.

M. Ann. Dist. of Columbia 21:316, June, 1952.

The Australasian Chiropodist

FROM AN ARTICLE by Wm. Bysack Kubig, M.S.Ch.:

The ignorant administration of a noxious appliance or remedy for a condition in which no remedy but time was required, has turned the scale in favour of the invading racketeer. On the other hand, of course, if the body should triumph in the ordeal, and any "remedy" has been administered, some portion of the credit is certain to be assigned to it, whether it were administered by an over-anxious chiropodist or by most ignorant and most unprincipled of quacks. The patient, as a rule, has but slender comprehension of the aims of ethical chiropody, and is therefore little likely to be in sympathy with them.

Revue de Podologie (Paris)

Judging from the following extract it would appear that society secretaries

in France are esteemed on a par with those in England.

(Translated).

"A word in conclusion"

If the Secretary sends a letter

It is too long.

If he sends a post card It is too short.

If he does not send a notice He is lazy.

If he assists at a committee meeting

He is overbearing.

If he does not come to the meeting

He does not care two hoots.

If he claims a member's overdue sub.

He has insulted him.

If he neglects to claim it He never does anything he should do.

If he asks for an opinion He is incompetent.

If he does not do so He is arrogant.

If he presents complete statements of accounts They are too long.

If he condenses them They are incomplete.

If he speaks about a question He wants to run the show.

If he remains quiet He takes no interest in what is said.

BUT in any case, if the others do nothing, the secretary must do it!"

Chiropody Record (U.S.A.)

S. L. PERLMAN, Pod.D., offers the following suggestion:

Pack nail grooves with prisms of foam rubber cut from a corner of 1/8in. foam sheet. First put a drop of rubber cement in nail groove, then dip the foam prism in rubber cement. Let both areas of cement dry and then work the foam rubber along the groove and under the corner. It will stay in the groove an indefinite period of time if left undisturbed and eliminate calloused nail grooves.

H. R. HARTLEY, D.S.C., gives the following details for making up a skin-adherent:

One quart of acetone.

Eight tablespoons of powdered rosin.
(Both items may be obtained from wholesale drug house).

Mix in wide mouth quart jar and pour into small mouth quart bottle to fill dispenser.

Advantages.

Rosin, the adhesive ingredient in plaster sticks, goes into complete solution, is non-toxic, an effective adherent and economical.

LETTERS

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal.

MINISTER'S ANNOUNCEMENT

SIR,—Surely the recent pronouncement by the Minister of Health has knocked the self-created pedestals from beneath the feet of the misguided men who have maintained a state of disunity in our profession.

Can it not, for once and for all time, be realised that there are good, bad and indifferently trained chiropodists in all organisations and that many are members of no organisation.

Let the two main organisations come together and thereafter form a register of all chiropodists and apply for state registration. This is the one and only, repeat only, way by which we can establish our profession. Forget about the B.R.M.A., that body which has had ample opportunity to help, but if help has been given the chiropodist has had none of it. Finally, ask the 'old dears' in the three front rows to abstain from voting upon issues affecting the future of the profession and we may get somewhere.

We are not alone in our troubles. The physiotherapists are also suffering for their ill-chosen policy and the more progressive and far seeing of them are also hindered by the group who gaze in superstitious awe of the 'medicine man.' As a whole our profession is not really very civilised, but I do think there are those in it who

could steer an independent course and achieve the status gained by our brothers overseas, particularly on the North American Continent.

CHARLES IAN STEWART, D.S.C.
Glasgow.

A DECISIVE BLOW

SIR,—I was very interested in Mr. Mercer's article in the February edition of the *B.C.J.*, and the manner in which he explained the position. Also I am entirely in agreement with his remarks and conclusions. There can be no doubt that a decisive blow has been dealt to those favouring an isolationist policy.

Always being a strong advocate for a united profession, I applaud the Minister's decision as this may tend to force matters. It is regrettable that we have had to wait for this before realising that some form of unity is essential.

The decisive step already taken will, as Mr. Mercer rightly says, lead to further steps. If we now unite we will be in a stronger position to further the necessary action for chiropodists to be granted a charter similar to that enjoyed by the dental profession. It will then be impossible for anyone to practice chiropody unless they have attained the requisite standard. This is what the individual chiropodist in private practice needs most, and would also greatly protect the public.

From the point of view of the general public this is long overdue, and is essential if the profession is to make progress.

IAN T. CARSTAIRS, M.Ch.S.
Brighton.

NOTES AND NEWS

Schemes for the Aged

AT THE ANNUAL conference of the Scottish Council of Women Citizens Associations, held at Largs, Scotland, recently a resolution from Glasgow asked that a chiropody service be provided for necessitous elderly people.

Miss Henry, Glasgow, who moved the resolution, said that chiropody, except for hospital treatment was not part of the National Health Service, although there was provision for a limited amount of domiciliary work.

A SCHEME for providing free chiropody treatment for old people is now being implemented by a sub-committee of Durham City Council Welfare Committee.

IT WAS REPORTED at a meeting of the Twickenham old people's welfare consultative committee recently that of the five old people's foot clinics in the borough all were very busy, except the newest one at Powdermill Lane, Twickenham, which could do with more clients.

NEWCASTLE COUNCIL of Social Service has given 300 foot treatments at 2s. 6d. a time to old people affiliated to the council during the period from September, 1953, to March, 1954. It intends to the scheme to cover more old people very soon. The council pays the attendant chiropodists a small retaining fee and pays for the cost of dressings. Patient fees do not cover costs and at present donations are making the scheme possible.

The Rev. James L. Cottle of the Newcastle Council of Social Service paid tribute to the eight members of the Joint Council of Chiropodists who are giving up time to treat old people for a very small fee.

Mr. Cottle also said that he was appealing to the chiropodists' professional organisations to allow their members to help.

IN A RECENT LETTER to the *Glasgow Daily Record*, Mr. Charles Ian Stewart, Superintendent of the Glasgow Foot Hospital, writes that although he is far from suggesting that the needs of necessitous aged and infirm foot sufferers who are unable to attend a foot hospital are adequately met, he does, nevertheless, invite the *Glasgow Daily Record* to make appointments for those necessitous foot sufferers with whom it is in touch. The Glasgow Foot Hospital has eighteen operators prepared to devote part of their time to such work.

In addition to those old people known to the *Glasgow Daily Record* a further 7,000 old people will be informed of Mr. Stewart's offer by Mr. Andrew Atkinson, secretary of the Glasgow Old People's Welfare Committee.

IT WAS POINTED OUT by Dr. Gordon Scott, M.A., Chairman of the Oxfordshire Association for the Care of Old People, in his recent survey of conditions in rural Oxfordshire, that the great disadvantages of chiropody centres at old people's clubs, which are so very popular and do so much good, is that they need subsidising fairly heavily and that they are of service only to the limited number of people (many of them elderly rather than old) who belong to the clubs. In the City of Oxford, which is well organised, only 10 per cent of the people of pensionable age belong to such clubs.

Dr. Scott also said that unless a chiropody service for old people were comprehensive it could not be adequate. A comprehensive chiropody service would

prove exceedingly costly and none of the statutory authorities was empowered to help with finance.

The chiropody service, started at Temple Cowley, Oxford, Old People's Club in February, 1952, for old folk unable to afford the normal charges, has now been extended to eight other clubs at 2/- a time. About 1,000 treatments have been provided so far.

Health Seminar

SIXTY DELEGATES attended the Seminar for Medical Officers of Health organised by the Central Council for Health Education at St. John House, Collingham Gardens, London, recently.

In the afternoon parties of delegates toured two factories to see shoes being made by mass-production and hand methods. Lectures and demonstrations on foot health education methods and media were given by Dr. W. Emrys Davies.

A discussion panel took as its subject "Foot Defects—Where Does the Cause Lie?" and it was suggested that a team consisting of a school medical officer, chiropodist and physiotherapist would form an efficient team to prevent foot deformities arising among children.

Lt.-Col. J. M. Milne, Advisor in Physical Medicine, R.A.M.C., reported that 80 per cent of army intake showing foot defects were handed over to the physical training instructor, and that 60 per cent of defects were postural or connected with the foot. Foot infections, he said, were not a major problem.

Foot Health Bureau

THE FOOT HEALTH Educational Bureau has recently issued a statement in which its purpose is defined as a medium for educating health workers and for disseminating knowledge on foot health through educational authorities and the Press. One of the chief functions of the Bureau is the organisation of discussions in which

trade experts and professional men can participate.

The Bureau recently held at Birmingham an exhibition of public education on foot health.

Nottingham Health Fund

IT WAS ANNOUNCED at the annual meeting of the Nottingham Health Fund that in 1948 the Nottingham General Dispensary employed only two chiropodists. In the same year the Health Fund was formed and its members became entitled to free chiropody treatment at the Nottingham General Dispensary. Now the dispensary employs 15 chiropodists and in 1953 the fund paid to the dispensary £3,400 for 25,000 treatments.

The president, Mr. R. L. Henry, pointed out that for fourpence a week a whole family could receive free chiropody treatment.

Foot Survey

THE RESULTS OF A survey on fifteen hundred schoolchildren in the East Riding of Yorkshire were given at the Royal Sanitary Institute's Foot Health Exhibition, recently held at the Museum of Hygiene 90 Buckingham Palace, Road, London, S.W.1. It was found that less than 3 per cent of the children had perfect feet and that at the age of 16, 88 per cent of girls and 67 per cent of boys had developed bent toes, signs of this having appeared in some cases at the age of two.

Examples of the pre-twentieth century idea of footwear flexibility appeared in a display of ancient shoes.

Fire in Surgery

MR. R. J. H. LYONS, a chiropodist with a surgery at 143 Becontree Avenue, Ilford, suffered a fire, causing damage worth about £80 and putting his surgery out of commission for several days, due to a bottle of ether falling from a shelf on to an electric fire.

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LESSONS OF THE PAST Chiropody is practised in this country by a great variety of people having had greatly varying degrees of training and experience. So far the profession, if at present it can thus be described, has produced nobody capable of taking its affairs in hand from a national standpoint and imposing upon all practitioners a uniform code of ethics and standardised training and qualifying examinations. This subject has been in the minds of many of us for the past twenty years and great efforts have been made by honest and ethical pioneers to found the nucleus from which a worthy profession might be developed.

From the point where there was no organised profession one association after another sprang up and each made genuine efforts to found an ethical body by establishing training schools and boards of examiners and imposing a high ethical code upon its graduate members. Thus, the interest of highly placed members of the medical profession was aroused and each organised body could boast its list of medical vice-presidents who were both constructively helpful and genuinely interested in the progress and welfare of the profession-to-be and gave it every encouragement.

As a result of these separate efforts, and in spite of considerable antagonism it gradually became recognised that the aims and objects, and also the general idea as to training and examinations, of these separate bodies were fast approaching a state of equality which justified a united effort on the part of two of them to obtain public and official recognition from the medical profession, which was accorded in 1938. As a result, the Chiropody Group Council was brought into existence, chiropody was recognised as a branch of medicine, and chiropodists governed by the C.G.C. were registered as registered medical auxiliaries.

From the start made by the British Association and the Incorporated Society the member bodies of the C.G.C. were gradually increased to five in number until in November, 1945 these five organisations gave up their separate identities and merged to form the present Society of Chiropodists. Great hopes were entertained at that time that this amalgamation would enable the profession to employ one mouthpiece to voice its aims and ambitions. It was anticipated by many that early efforts would be made to secure a widening of the outmoded definition accepted under the C.G.C. and that

strenuous efforts would be made to secure state recognition. These hopes were not to be fulfilled, for the voice was silent and the efforts were not made, and indeed the Society was not left to occupy the field alone; the Joint Council of Chiropodists were endeavouring to make known their views for the profession and were growing up alongside with increasing strength. The weight of the Society imposed on the J.C.C. the need for strenuous effort and there is little doubt they did all they could to increase their strength numerically, adjust their requirements of ethics and training and conditions of membership. Thus, in recent years they have hewn for themselves by bold and positive action a place in the chiropodial scheme of things which cannot be ignored either by other chiropodial organisations, or as we have seen at various times, by local authorities, parliamentary committees or even by the Minister of Health himself.

Up to the present time chiropody has had no legal status whatever. At the present moment a limited official recognition by the M.O.H. is in process of preparation as a result of the need felt by the M.O.H. to determine what sort of qualification was needed for a chiropodist desiring to be employed under the National Health Service. Those fulfilling certain easily defined conditions are automatically declared eligible, whilst lists are envisaged which will include others whose claims to eligibility whilst not being so simple to define are bona fide, sound and undeniable on grounds of training, ethics, examinations and years of public practice. This we should be able to leave safely to negotiators from the bodies concerned whose duty it is to protect the interests of their members.

It is to be hoped that as a result of the M.O.H.'s investigation it will be found that to have been admitted as a member to either of the qualifying bodies, will very

soon, ipso facto, be accepted by the M.O.H. as proof of eligibility to apply for posts under the National Health Service. Investigations will injure nobody and it is to be hoped that the result will justify the average member's faith in his own organisation that if a person has been admitted into membership on grounds of training, knowledge and ethical practice he is a worthy member and entitled to the whole weight of the organisation in his protection. Indeed, it is only such comprehensive lists which could adequately support established claims for integrity on the part of the qualifying bodies; and it is only such complete lists which could possibly form the basis of a register on a national scale such as would be required for any scheme of state registration.

The M.O.H. has rendered chiropody a service by obliging the Society and the Joint Council to face each other and talk business, even if for the moment it is mainly his own business. Who knows, they may even learn to like each other; and we hope they do.

J.C.C. DELEGATES' CONFERENCE

This annual conference was held at Bournemouth on May 1 and 2, when by courtesy of the council, the Hon. Editor and a representative of the *British Chiropody Journal* were cordially invited to attend as observers. Our contributor, "Vigilant" found it possible to spend the Saturday with them and his report will be found in this issue.

We need hardly say that both the editor and the publishers very much appreciate the cordial invitations and the manner in which our colleague was received. We regard this gesture as a token of J.C.C. sincerity in chiropodial affairs.

OBITUARY We deeply regret having to record the passing of one of chiropody's deeply respected figures, Mr. S. C. Addis;

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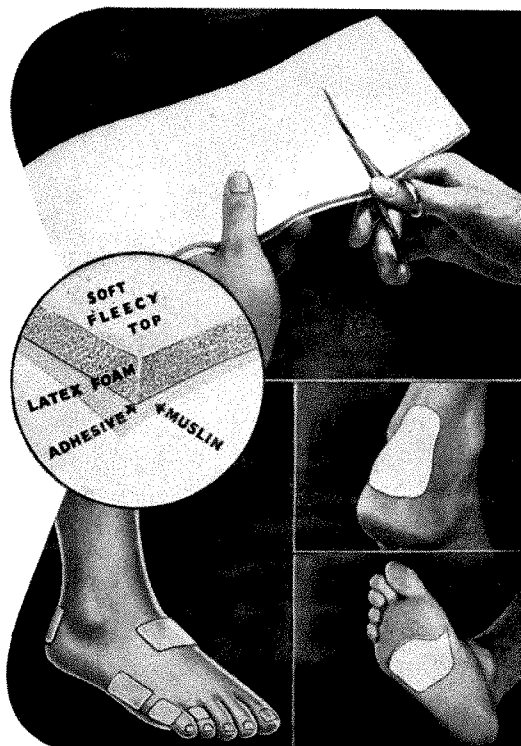
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F.Ch.S. One of the old school, he first qualified with the Incorporated Society of Chiropodists and then later became an integral part of the British Association of Chiropodists, taking his place on council and committees. For a number of years he was principal in charge of the Westminster City Foot Hospital and School of Chiropody.

There is little doubt that the whole of his interest and his affection was centred in the British Association where he was regarded with genuine affection by everybody who came in contact with him. His students regarded him as a father

and one will never think of Mr. Addis without seeing that ever-present smile and kindly expression.

He was truly established in the hearts of those who knew him, a gentleman at all times, seldom ruffled, a man we were all glad to know and felt better for the knowing. We sincerely offer to his sorrowing family our heartfelt sympathy in their loss and we trust it may help a little for them to know that at least all the members of the old British Association are conscious that they have a part in that loss of a dear and respected colleague and friend.

PREDISPOSITION TO HALLUX VALGUS

by W. D. Watts, M.Ch.S.

THE etiologies which have been postulated for hallux valgus are numerous and varied and cases are seen which demonstrate the possible applicability of most of the generally recognised hypotheses, yet the nature of the theories may be widely dissimilar. Two possible suggestions arise from this: the first is simply that the one deformity may have a number of causes which may be quite unlike, and the other is that the numerous apparently different causes are in fact precipitating factors whose influence upon a common predisposing factor produces the deformity.

Although the possibility exists that quite dissimilar factors could produce the same effect, if the first explanation were correct it would be reasonable to expect that, although the deformity might be approximately similar in character, typical variations would exist and could be related to the individual causative factors. However, other than variations in degree the condition does not seem to be divisible into such types.

Of course, it must be admitted that the existence of such type variations is not

absolutely essential to the plausibility of the first explanation; their existence would, however, support it. As it is, the explanation must stand with uncertain foundation, and even if such type variations were not essential to the explanation it might, at least, be expected that in this group the various reputed causes could be traced in each individual case.

The evidence which can be marshalled in support of the second explanation is of more concrete substance and the purpose of this paper is to discuss it.

A basic predisposing factor, if it exists, must be found within those factors which are common in all cases. In the foot and its environment the only such group which is common is that of the fundamentals of the integral structures and their individual functions.

The maintenance of mobile toes in an undeformed state is very largely dependent upon a balanced antagonism of the muscles which act upon them. When this balance is disrupted and one of the opposing factors asserts itself to a predominant influence, a tendency for eventual movement from

the passive neutral position exists and will operate unless sufficient resistance is available, the new position being one which is dictated by the action of the predominant muscular influence.

The majority of non-congenital and non-traumatic deformities of the toes are probably attributable to an imbalance in the antagonistic musculature which acts upon or from them. A notable example is seen in retraction of the smaller toes by an overactivity of the long extensor to these digits. A similar etiological pattern is also obvious in hallux flexus and rigidus where a continually predominant flexion may eventually produce a position which is permanently divergent from the neutral. Conversely, a digital deformity arising from a muscular imbalance which is initiated by inaction can be seen in claw toes, which may follow failure of the lumbrical muscles.

It is, then, established and obvious and can be definitely asserted that the muscular influence upon digital deformity is, at least, a major one and probably the main underlying factor.

Accepting this, it is surely significant that with one exception the muscles which act upon the hallux all arise from a laterally placed aspect of the foot or leg and are inserted mainly centrally or laterally in the hallux. Thus, in addition to whatever their primary action may be, they exert an adducting influence upon the hallux, in relationship to the mid-line of the foot.

In the case of some of these muscles, possibly the flexors, this adducting influence may be argued to be slight, but complementarily in others it is considerable. This is particularly true of the long extensor, but whatever the individual degrees of effect there is no doubt that the sum effect is predominantly an adductor one.

- There is, of course, opposition to the predominantly adducting influence of the majority of the musculature. This is

ligamentous, osseous and in the one abducting muscle, the abductor hallucis, ligamentous restraint upon deformation can be accepted without elaboration. Similarly it can be seen that osseous restraint is present in the four smaller toes, which when functioning efficiently, may provide an effective stop to the first toe's lateral deviation. That the first toe in its valgus journey must first break down, this stop is seen from the under—or over riding second toe, which accompanies hallux valgus. In the majority of adults, although the abductor hallucis is a muscle incapable of exerting an actively abducting influence upon the hallux, its presence does exert some resistance to adduction. In this sphere there may be some significance in the fact that in the young child, where active abduction is possible, hallux valgus is rare.

It follows that these three factors which resist adduction of the hallux are vital and impairment of their efficiency may precipitate hallux valgus. It is also fairly obvious that the scales are somewhat loaded against the three resisting factors which have been mentioned, for their combined might is not considerable when compared with that of their opposition in the form of musculature, footwear, and gait.

Thus, a high incidence of hallux valgus is to be expected if the postulated predisposition is fact, and hallux valgus in some degree is an exceedingly common deformity.

It may be argued that although this predisposing factor is present in every individual, with almost no exceptions, not every individual presents hallux valgus. The fact is, of course, as already stated, that the vast majority do develop hallux valgus of some degree, but this need not demand clinical intervention unless the degree is extreme. And, of course, here the question of precipitating factors arises and obviously these are not universally identical. Furthermore, a minor degree of deformity is not regarded as abnormal and

so arouses little notice.

To quote statistics, Lake in *The Foot*¹ gives figures compiled by Dr. E. H. Wilkins and by Mr. J. Keen, F.R.C.S., which show that in two different groups the incidence of hallux valgus was respectively 25 per cent and 27 per cent. Furthermore, the first of these groups was a juvenile one and hallux valgus in these surveys was only recorded when divergence was more than 10 per cent. In quoting from a report on an examination of school children Furniss² states that 40 per cent of the girls, and 27 per cent of the boys in the lower age groups exhibited hallux valgus. The deformity here was usually accompanied by inflamed bursae, so it can be assumed that the degree regarded as deformed was again considerable.

It is interesting to note that in an inspection of children's feet Sagar³ noted that the tendency to hallux valgus was present not only in those boys wearing obviously deforming shoes, but also in those who were more suitably clad. This again points to a common underlying factor.

In another survey of children's feet Craigmile⁴ found that in a 10-15 years age group 56 per cent of girls and 40 per cent of boys examined demonstrated hallux valgus.

It should be noted that the figures given above are, with one exception, based on examinations of children's feet, but hallux valgus is a progressive condition, the highest incidence of which is seen in later life. Thus, the quite high percentages of abnormally regarded hallux valgus already apparent in youth demonstrate clearly the prevalence of the condition.

In discussing hallux valgus Hanby and Walker⁵ state "...that in a recent analysis of a group of female patients of forty years of age and over there was scarcely any one of them who did not possess the condition either in mild or severe degree." And there is little doubt

that some degree of hallux valgus exists at some time in the majority of adults in both sexes.

This further points to the existence of a widely, if not universally, present predisposition which is probably necessarily a structural factor.

It is a striking fact that hallux valgus rarely exists as a single isolated state, but usually co-exists with a quite general disorganisation of the foot and in particular with pes valgus. This can, of course, be explained by a realisation of the importance of the first metatarsal segment, disorganisation of which can quite plausibly be taken as the instigator of more widespread disorder in the foot.

This explanation, it must be admitted, is strong, but it may also be considered that the pes valgus may have precipitated the hallux valgus for in pes valgus digital function is impaired and in a majority of cases there is some clawing or retraction of the toes; there is in addition strain imposed upon the ligamentous control of the forefoot and upon the abductor hallucis. Thus, the resistance to the predominantly adducting musculature is enervated.

If it can be established that pes valgus, in these cases, precedes hallux valgus then further support may be gained for the hypothesis that a main predisposition to hallux valgus is a predominantly adducting musculature.

The question of which condition comes first or whether both are simultaneous is a difficult one to reconcile, but some pointer may be found in a comparison of the incidence of both conditions in childhood and in maturity. For if there is a predominance in occurrence of one of the deformities in childhood and an increase in the other in maturity then some indication of the primarily occurring deformity may be gained.

Quoting again from Dr. E. H. Wilkins, Lake⁶ states that in a group of children

between 11-15 years, the numbers with good arches were: boys, 50 per cent; girls, 59 per cent; the remainder exhibited some degree of pes valgus. These percentage figures for the incidence of pes valgus are far in excess of the majority of figures previously given for the incidence of childhood hallux valgus. Craigmile's figures are the only ones of which this is not true and in those the figures are approximately the same. Yet in maturity it has been shown that the incidence of hallux valgus is much greater. •

In a recent survey of 50 adult cases with pes valgus it was found that 74 per cent also had co-existent hallux valgus, which figure excludes minor degrees of hallux valgus. Hanby and Walker's statement that in a group of female patients of forty years of age and over there was scarcely any one of them who did not possess the condition either in mild or severe degree, is, I believe, generally found to be the case.

If, as is almost certain, hallux valgus and pes valgus are closely related it would seem that in most cases it is likely that pes valgus precedes hallux valgus and it is possible that the digital deformity may in such event result from enervation of the opposition to the predominantly adducting musculature.

While to criticise the wisdom of nature may be to tread an uncertain path it might be considered unreasonable on the part of nature to endow man with apparently only one definitely abducting muscle to the hallux, but in this assessment the question of the effect of pedal environment upon function must be included.

Although the role of footwear in producing pedal disorder may be minimised or exaggerated according to differing schools of thought it is obvious that, considering the discrepancy of incidence of hallux valgus in shod and unshod races, it cannot be ignored in this question.

With the adoption of footwear and pre-

pared walking surfaces civilised man in his questionable wisdom has created a synthetic pedal environment which only permits a somewhat stereotyped repetitive function. Thus, in the foot muscular activity follows a rigid course with little or no individual muscular variations in function and effect. This doubtless emphasises the effects of the muscular activities in their particular roles, and furthermore it concentrates the effects of muscular activity to a narrow pattern and denies the versatility which may be essential to the maintenance of a balanced and unbiased position. In the unencumbered naturally existing foot versatility of movement and general pedal function demands a versatility of structural positions and therefore of muscular activity which should help to prevent the development of a persistently predominant effect by ensuring the existence of opposing actions.

It follows that the more restricted the pedal environment the greater will be the stereotyping of activity and the likelihood of a developed bias.

In short, in the naturally existing foot opposition to the development of a predominantly adducting musculature arises from the fact that the versatility of function which is demanded ensures that muscular actions and effects are diverse and are not concentrated to constant and rigid patterns which are without complementary opposition.

Since pedal environment is largely decided by footwear it can be seen that the more restrictive the footwear is the greater may be the tendency for structural bias to develop. Conversely, the less restrictive the influence of footwear is the greater should be the functional versatility, and therefrom the tendency to bias should be reduced.

Conclusions

If the foregoing hypothesis be accepted some obvious conclusions may be drawn:

First, unshod function should be encouraged whenever possible and particularly in the developing foot.

Secondly, a revolutionary approach to footwear design and habits must be made, particularly in regard to female shoes which must be adequate enough for complete functional freedom if the problem of hallux valgus is to be effectively attacked. In addition, shoe soles might beneficially be made of a mobile substance so that variety of movement within the foot is permitted and encouraged.

Summary

It is suggested that hallux valgus, being such a frequently occurring deformity, probably has a basic predisposing factor and that this must be found amongst those factors which are common to all cases. The only such common factor in the foot and its environment must be found in the intrinsic structure and it is suggested that the predominantly adducting influence of the musculature acting upon the hallux fills this role.

It is realised that the figures which are quoted are from disconnected surveys and may not for that and other reasons be decisive, but it is felt that the basic facts which the figures have been chosen to emphasise are generally recognised, especially that pes valgus in childhood occurs more frequently than hallux valgus

and that the incidence of hallux valgus in maturity is overwhelmingly greater than in childhood. From this it is suggested that in many cases pes valgus precedes hallux valgus and may contribute to the deformity by reducing the effect of the factors which oppose the predominantly adducting musculature.

It is thought that in the naturally existing foot the versatility of function which is demanded ensures complementary and opposing muscular activities whereas in the shod civilised foot versatility of muscular function is prohibited and a narrow stereotyped pattern of function operates and increases the likelihood of the development of functional and therefore of structural bias.

It is concluded that unshod function should be encouraged whenever possible and that footwear which permits free and versatile function should be adopted.

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THE WEAKFOOT CONCEPT—Part III*

by L. F. Schreiber, F.A.A.C. (Hon.), F.A.C.F.O., and
H. W. Weinerman, D.S.C.

NATURAL PRONATION IN LOCOMOTION

In the act of locomotion, countless changes in position of each segment, in relation to all other segments, take place at the precise moment. In a

smoothly functioning mechanism of this sort, multiple factors are involved, for example, in the feet. In the complete cycle of the forward progression of the body, not only does each foot alternate in going through the act of a lever, but the intricate inner workings produce various

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changes in position, both while actively engaged during weight-bearing and during the swing through space preparatory to taking the next step. In the course of the cycle making up the step, the foot expands and elongates during the active phase and recoils or contracts during the passive phase, assuming different positions in both phases. The slight changes taking place on the weight-bearing phase produce a relatively different position of the structures in contrast to the non-weightbearing phase. Any change in relative positions during the cycle is to be construed as strictly functional, having no relation to faulty foot mechanics such as pronation, in a pathognomonic sense.

In similar manner, stance requires voluntary muscle balance to maintain the upright position of the body. Pronation is likewise common in stance, just as it is during the active phase of momentary weight-bearing in locomotion. The point is that since pronation occurs in locomotion as well as in stance, no issue is made of this phenomenon, by authorities, when it occurs in locomotion. The evidence indicates that the change in the cyclic position of a part represents its natural dynamic activity and is not due to faulty function (work) of the structures.

However, there are times when a change in the position of a part is desirable from a functional, rather than from a structural, point of view. For example, placing elevations under the foot at certain strategic points in order to bring about a change in functional position during locomotion will ultimately remodel the internal architecture, representing the fulfilment of the requirements. But, on the other hand, if a deformity results from placing the foot in an abnormal position, the anatomic result is merely the effect of having functioned in that position for a period of time commensurate with the

changed function due to the changed position. (cf. Davis's law).

FALLACY OF THE WEAKFOOT CONCEPT

Up to this point, the material presented has been an attempt to set the stage for what is now to follow. To revert to a statement in converse of that made in the first part of this paper, those who are "indoctrinated with habituated forms of thinking in the realm of the scientific" will receive a scientific shock upon reading of a similar shock experienced by Wilson,¹⁹ who "was astonished to find Igorrotes with good functioning flatfeet," an experience he narrates as follows:

"On one occasion there was in Philadelphia, some four years ago, a troop of Igorrotes: and I had twelve or fourteen of these little people come to my clinic, as I wished to show the students what natural feet were like. The subjects varied from five to forty-two years of age, and I put them on a high platform, but as they walked across, I was horrified to find that I was wrong in my conception of a natural unclothed foot. These people, in whom I had expected to demonstrate a perfect arch and a perfect foot, all stood flat-footed, with the feet *pronated* in the position that I had used to demonstrate the necessity of mechanical support; yet they had superb, flexible feet, superb musculature, and capabilities beyond conception. If plates had been applied they would have beautiful arches. My students were appalled, because I had taught them that a natural foot should stand foot-straight, with the arch preserved. I was aghast at the prospect of not being able to reconcile the feet of the savages with my conception of a natural foot; but through the suggestion of one of the students, *I was finally able to show them even though these feet appeared pronated when standing, their arches in action were the standard*

normal arches. Therefore, the foot was a capable foot."
(Authors' italics).

This experience, of a serio-comic nature, only goes to show that so-called weakfoot is a nondescript misnomer, a nonentity of sinister scientific propensity, best recognised under the heading of "scientific guesswork." Hiss²⁰ states that "'Weak-foot' is another antiquated term that means nothing in particular," to which we may add—*particularly nothing!*

The foot of the Igorrote shows no phylogenetic difference compared with the foot of western civilisation. This similarly further shows that subtalar pronation is neither acquired nor structurally deficient, but is an architectural foot type of a variety common among many tribes as well as civilised man.

From the evidence now accumulating in the field of orthopodics, as represented by the spiralling intensity of interest shown by investigation into the subject, it is likely that the weakfoot concept cannot long survive the onslaught. The more the profession keeps abreast of the findings in anthropology, the less it is likely to adhere to artificial and antiquated ideas on foot structure and architecture while overlooking natural foot function. Yet, in spite of all therapeutic attempts to throw the centre of gravity of the body out of balance by overcoming pronation, it continues to persist in barefoot stance and in locomotion, as it naturally should in a foot of that type.

Incidentally, the foot is the only organ of the body that is held to be architecturally imperfect from the orthodox standpoint, when judged on the basis of the weakfoot concept. As a warning to avoid being misled by the use of the word "ideal" in connection with anatomic form, F. Wood Jones²¹ makes this arresting statement: "It is a little difficult to know why

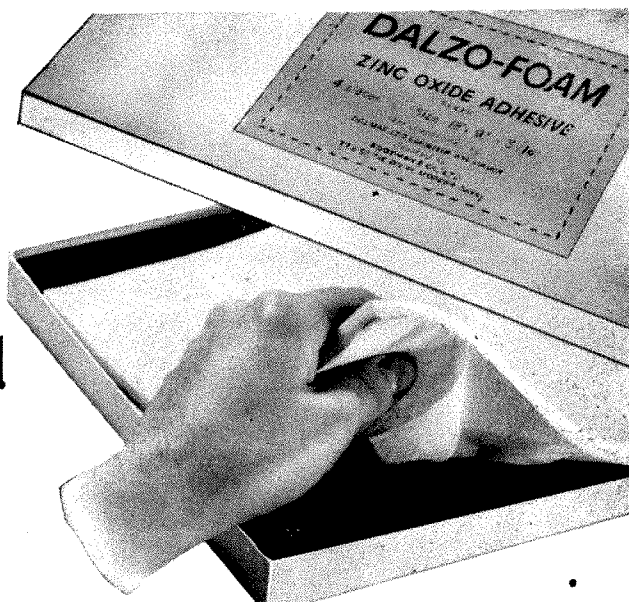
the human foot should be selected as an organ that is assumed to have an ideal or perfect form differing from that which the anatomist finds to be normal in the vast majority of mankind. If we substitute 'normal' for 'ideal' in the above sentence, we must conclude that the bulk of humanity is condemned by the normal disposition of the bones of the foot to show some departure from the normal functioning of the foot. The only alternative is to assume that there is such a thing as ideal foot function and that this function could presumably be carried out by an ideal but not by the normal foot."

One of the world's foremost anthropologists, Jones, dispels the false notion still taught by small-fry "scientists" regarding the evolution of human locomotion from quadrupedal to bipedal means of progression, stating that "It would be better to discard all the drawings that depict the early progenitors of man as slouching brutes carrying themselves in postures incompatible with the dictates of gravity, and to relegate to oblivion all the speculations and theories concerning the gradual rise of man from a quadrupedal pronograde to a bipedal orthograde posture." (*Hallmarks of Mankind*).

THE ARCH: RIGID OR FLEXIBLE?

A great deal of controversy regarding the weakfoot concept may be resolved by a consideration of the foot as a structural unit of great integrity. Authorities are divided as to opinions concerning the rigidity or flexibility of the arched structure. Of eleven authorities whose opinions we culled on this question, four consider the arch a rigid structure, six consider it flexible, and one is contradictory within the space of five pages (p. 261 and p. 266) in his famous book on locomotion. Tabulated by name and publication, the opinions of these authorities follow:

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NAME	PUBLICATION	OPINION
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Gray	Anatomy, ed. 27	Arch resilient
Cunningham, D. J.	Anatomy, ed. 7	Semi-elliptic spring
Callander, C. L.	Surgical Anatomy, ed. 2	Arch resilient
Grant, J. C. B.	A Method of Anatomy, ed. 2	Arch is a spring
Morton, Dudley J.	The Human Foot	Arch a rigid structure
Keith, Arthur	The History of the Human Foot, etc.	Arch flexible
Lapidus, Paul W.	Misconception "Springiness" of Arch	Foot a rigid lever
Lake, Norman C.	The Foot	Arch Rigid
Engels, W.	German works (1904)	Arch Rigid
Jones, F. Wood	Structure and Function in the Foot	Arch flexible, resilient and elastic

The obvious extremes of opinion expressed by the authorities in this tabulation seemingly have one thing in common: *They do not tread on middle ground.* It would be presumptuous on our part to contradict these authoritative opinions if opposed at the extremes they represent. However, we may seek refuge in the wide open spaces of the comparatively safe middle ground on which angels fear to tread and where we may rush in uninhibited. It may be that ours is a voice in the wilderness of conflicting opinion, and it might be drowned by those who are "indoctrinated with habituated forms of thinking."

In voicing an opinion upon the virgin territory of the middle ground, our approach to the problem is made on the basis of personal anatomic and structural observations, supported by authoritative findings concerning elongation and tensile strength of fascial structures²², supplied by engineers who made a study of the subject in connection with the conclusion that *the arch is a rigid lever.*

If the arch is held to be a rigid structure, we may disregard the rearfoot as capable of flattening. But we have observed that the *forefoot* is capable of lateral or medial torsion—a frequent cause of instability and, therefore, interfering with normal

locomotion. Cophart's articulation further reveals that it is capable of slight movement on its horizontal and vertical axes, which makes it appear that it is a free-functioning unit (within limitations), while the rearfoot (talus and calcaneum) remains relatively stationary. This makes of the arch a semi-flexible lever, with the anterior fulcrum at the metatarsophalangeal articulations. Thus, the forefoot is particularly vulnerable to shock and excessive wear and tear because it has little anatomic support from the comparatively sturdy rearfoot construction.

In this connection, there is one anatomic pillar of strength in the skeletal structure of the foot which we wish to point out that has not, to our knowledge, received any attention in the past in considering the so-called weakfoot posture. By closely scrutinising the anatomic formation at the subtalar articulation, it will be observed that the posterior view reveals a wave-like process resembling faintly the letter S lying on its side. The peculiar formation in the joint, and the opposing platforms lipping on both sides of these bones forms an interlocking device which provides bilateral stability at the site of the projecting process, the sustentaculum tali, reinforced by the calcaneo-navicular ligament.

(to be continued)

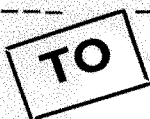
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HISTORY REPEATS ITSELF

by G. Stanley Mercer

I WROTE this paragraph just over five years ago:

Unless the two major chiropodial organisations meet together in conference officialdom will assuredly step in and force the issue sooner or later. and repeated the warning many times since. Whilst the prediction was supported by many, other responsible people scornfully rejected it. We know now that the warning was well founded.

By the time this issue is circulated representatives of both the Joint Council and Society will have met in conference, not by mutual consent, but by direction and under the authority of the Ministry of Health.

And so history has repeated itself. It was in 1936 that the late British Association of Chiropodists invited the then Incorporated Society of Chiropodists to confer in regard to matters affecting both organisations. This and many subsequent invitations were promptly rejected. In 1938, both organisations were officially accepted to official registration by the Board of Registration of Medical Auxiliaries, and it was by direction of the board that the two organisations met in conference and formed the nucleus of the Chiropody Group Council. It will be seen therefore that officialdom forced the issue in 1938 just as it has done in 1954. Indeed, the whole set of circumstances are strikingly similar, except that the Joint Council has this time played the role of the British Association and the society that of the Incorporated Society.

It is, however, significant that the same regime is responsible for the serious mistakes in both eras. What must be the trend of their thoughts now? Will they

acknowledge the damage done by their stubborn insistence upon an isolationist policy? I feel so strongly on this subject, that perhaps I had better let it rest there.

MY CONTRIBUTION last month has produced my largest-ever correspondence. Members of the Society have taken me to task for suggesting that "it is the constitutional right of every member to voice his dissatisfaction." The following are some extracts of letters I have received. Mr. D. writes:

What rubbishy nonsense you write. The rank and file of the Society may have certain constitutional rights on paper, but let any one of us try to put them into practice. To use one of your own expressions, we might just as well try "pushing down a brick wall with a feather."

Mrs. S. writes:

Supposing it was made easy for all members of the rank and file to express themselves freely, chaos and confusion would result, as the Society's membership runs into some thousands.

Mr. W. writes:

In a body such as the Society, the only way in which members can convey their views to their colleagues at large is by free expression in the Society's journal.

He then questions whether *The Chiropodist* gives sufficient space to general discussion between members.

In reply to Mr. D., I would remind him that events of the recent past do not support his theory.

In reply to Mrs. S., I would suggest that the size of the membership does not affect the issue at all. The more members there are the greater the number of branches

and there surely lies one avenue open for free expression.

I sympathise with the point raised by Mr. W., but if the Society permitted the use of its journal as a sort of free forum it would probably have to be enlarged two or three times. It must be appreciated that the Society's journal differs from this publication in so far as it is the official organ of one organisation pursuing a set policy determined by its elected Council.

ARE WE APPROACHING the time when the profession will stage one great event designed to educate the public to the value of foot health? I earnestly hope so.

I appreciate to the full the splendid work already accomplished and sponsored by the footwear trade, but in the matter of foot health the chiropodial profession

should take the lead rather than play an incidental part.

I want to see the introduction of an annual Foot Health Week, divided into two parts—three days public and three days professional. Lectures, demonstrations, etc., could be arranged suitable to the interests of both.

An event of this magnitude would, I imagine, attract the interest of all those concerns engaged in chiropodial supplies, as well as the footwear trade, thereby making it possible to put on an exhibition of great attraction.

An event of this kind, however, is quite out of the question without the close co-operation of both chiropodial organisations. As explained earlier in this contribution representatives of both have met together. Here then is a major subject of importance for their consideration.

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Round and About

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MR. S. ADDIS

The passing of Mr. S. Addis, after only a few days' illness has come as a shock to his many chiropodial friends.

It was my privilege to be closely associated with Sydney Addis for almost thirty years. It was at my invitation that he became principal at the Westminster City Foot Hospital and School.

During his many years as a teacher some hundreds of students passed through his hands, many of them taking honours. He was a pioneer in the strictest sense of the term and played a big part in obtaining the professional status of chiropodists. Sydney Addis always cherished the hope that his profession would one day be closed by law to the unskilled. He did not live to see that day, but if ever it does arrive let us not forget him for the part he played by example and endeavour.

THEY MEET AT LAST

For the first time leaders of the Society and Joint Council have met officially in conference. It happened this month on the occasion of what is described as a "working party" meeting, under the authority of the Ministry of Health. Dare we hope that this meeting will lead to a measure of co-operation between the two organisations? It is a golden opportunity which should not be lost. Both

organisations enjoy the same official status and provided that one does not attempt to over-ride the other, much good should result from this first meeting.

THE REGULATIONS ARE NOT LOOSE

Most of us obtained the impression that the Ministry of Health regulations governing chiropodial appointments in the Health Service were sufficiently loose to permit of the easy entry of those older-established practitioners who do not qualify under the two years' training stipulation.

I am reliably informed that this is not the case. The Minister has made it known that the regulations are rigid in their application.

ANNUAL DELEGATES CONFERENCE

The annual delegates' conference of the Joint Council of Chiropodists was held at Bournemouth on May 1-2.

One cannot help but admire the way these conferences are conducted. There were some 70-80 delegates, all of whom had obviously been carefully chosen by the branches represented.

As is usual on such occasions there were two or three delegates who had rather more to say than others, but for the most part their reasoning was sound and well put over. Once or twice I thought trivial matters received a little more attention than was necessary, particularly in regard to finance.

The high spot in my opinion was the opening address by Mr. D. Stewart Forbes,

the council chairman; it was assuredly the finest chiropolitical address of recent times. Mr. Forbes is the perfect diplomat; his points and beliefs were expressed forcefully, but not once did he indulge in personalities, or become offensive to those who do not share his views. His review of chiropolitical events over the past quarter of a century reflected his complete knowledge of the subject. Mr. Forbes was critical of the medical profession's attitude in so far as the practice of chiropody is concerned; at the same time he was generous in his appreciation of the medical fraternity in its own field.

There was a good deal in the address with which I disagreed, but I freely confess that Mr. Forbes provided me with food for some very hard thinking.

I should like to quote one striking passage in Mr. Forbes' address which every chiropodist should ponder over. He said:

We have been given that which is

given to few, a second chance. Let us make full use of it. Let us realise that our salvation lies within our own profession and, above all, let us not harbour malice against those of our chiropodial colleagues who in good faith took one direction whilst we elected to follow another.

In a discreet reference to the Society, Mr. Forbes went on to say:

We have offered to meet you in the past. We consider that a joint consultative meeting between our two bodies is now of vital importance, to the profession as a whole. Communicate your wishes to us and we shall willingly agree to meet you at the earliest possible date.

These sober words of wisdom were uttered with a real sincerity of purpose. I hope they will be fruitful.

It would be ungracious if I closed this report without a word of congratulation to Mrs. Clare Branch and her committee, for the smooth running of the conference arrangements.



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ABSTRACTS

From Our Contemporaries

Journal of American Medical Association

IN RECENT YEARS, real progress has been made in the development of new methods for the management of gout. A more rational approach to therapy, based on knowledge of the basic mechanisms of the metabolic defect in gout obtained from new methods of investigation, especially the employment of isotopes, has developed. The establishment of gout as an endocrine disease occurring in persons with hereditary susceptibility permits the physician to promptly recognise and treat the early stages of gout. Within the past few years, several new drugs have been introduced that produce profound biochemical changes and definitely influence the clinical course of this disease. The hormones corti otropin (ACTH), cortisone, and hydrocortisone (compound F) have a dramatic effect on the acute episodes of gout and provide new tools for further investigation of the pathogenesis of this illness. The concomitant use of corticotropin and colchicine as recommended by Wolfson, offers a promising new approach to the control of acute episodes of gouty arthritis. The prolonged administration of the urate diuretic drug probenecid (benemid) effectively removes the urates that are deposited in the joints and bursae, and recent studies in a limited number of cases have shown that its long-term use reduces the size of established tophi. The spectacular results already reported indicate that phenylbutazone (butazolidin) may be a useful drug in both the acute and chronic stages of this disease. If the occasional undesirable effects prove not to be serious hazards, this new pyrazole derivative will be a welcome addition to

the growing list of drugs of value in this crippling disease.

From the article by Unger and Unger.

Journal of Medical Association, Georgia (U.S.A.)

GOUT is probably one of the most neglected disease syndromes in the field of American medicine, yet is one of the oldest diseases known to man. The treatment of an acute attack of gout, after recognition, usually is a simple matter. Very few articular diseases will respond so promptly. The affected part should be put at complete rest. Hot or cold wet compresses give some measure of relief. If the pain is too severe, morphine or codeine should be used. Most authorities agree upon the treatment for acute gout, but there is some disagreement concerning the interval treatment or management between attacks. Some feel that moderate dietary restriction and avoidance of the use of alcohol is all the treatment indicated. The majority, however, feel that the gouty state can be combated and the development of deforming arthritis checked by a definite treatment regimen, consisting of (1) moderate living, with adequate rest; (2) a low purine, low fat diet; (3) colchicine, and salicylates with alkali, and (4) abstinence from alcoholic beverages. This treatment also is useful after gouty arthritis has developed. In addition, heat and moderate massage with active and passive joint activity should be used.

From the article by George R. Dillinger.

American Journal of Surgery

HOW MANY of us stop to think why it is that an open wound almost invariably remains free from infection, even when it is grossly contaminated? The reason is that the body fluids, blood and serum, flush the wound of dead and necrotic material, and at the same time make the

environment undesirable for bacteria. It is only during this initial or exudative stage of wound healing that infection occurs. Sutures placed in a wound at this time prevent the flushing action of these tissue juices and encourage the production of bacteria. During the last war the medical advisers to the Armed Forces, who undoubtedly were men of vast surgical experience, issued a general order that all wounds should be left open until they could be properly repaired. Thousands of young lives were saved because of this order.

Because of modern refinements in technique and anaesthesia, and because men are taken at an early age and trained in the art of surgery, each succeeding generation of surgeons is better in all phases of surgery. These surgeons know the rôle the antibiotics play in prevention of infection, but they also know that the living cell is still the greatest barrier to infection. They have the same respect for the single living cell as they have for the entire mechanism, be it asleep or awake. They know that unnecessary injury to one cell might be followed by death of the entire part.

From the article by Philip A. Caulfield, M.D., and Howard S. Madigan, M.D.

Journal N.A.Ch., (U.S.A.)

A SCHOOL foot survey was conducted recently by members of the Oklahoma Association of Chiropodists. All students in grades from one to twelve were examined. A similar survey was also undertaken at Duncan, Okla. The findings at the McCloud school are as follows:

Total number of children examined	448
Number with no foot problems.	120
Number with ill-fitting footwear only	70

Herewith is a report on the number of

foot conditions found:

Condition	Boys	Girls
Pes planus	10	2
Pes cavus	2	0
Pes valgo planus	82	84
Metatarsus varus	0	1
Foot or leg pains	5	8
Tylomata	17	10
Helomata durum	5	2
Verrucae	2	0
Hyperhidrosis	21	4
Bromidrosis	2	0
Hammer toes	2	1
Leg shortage	0	1
Onychocryptosis	4	4
Dermatophytosis	0	1
Abrasions	4	0
Bullae	1	0
Hallux valgus	0	4
Onychiauxis	1	1
Totals	158	123

Chiropody Record (Chicago)

EARLY IN PRACTICE we started seeking a medication which would be the most useful in the treatment of chronic helomae and tylomae. Finding that by using 10 per cent and 20 per cent solution of silver nitrate to reduced helomae molle with proper shielding and by further careful reduction and enucleation of the remnants along with the eschar after one week, we were able to cure about 90 per cent of these cases. Such was not the case with the two before mentioned lesions. Everything seemed to fail. After using all types and percentages of various keratolytics, astringents and emollients, we had our druggist prepare for us various strengths of silver nitrate in a cerate. The 10 per cent strength seemed most effective, being used in the following routine manner:

- (1) Reduction of lesion thoroughly.
- (2) Moleskin aperture just larger than

area reduced with further pressure padding posterior to lesion.

(3) Fill area with small amount of silver nitrate cerate and carefully cover entire arrangement with tape or gauze-tex. This dressing should be worn with comfort until the following visit to your office. Have patients remove dressings the night before next visit. (1-2 or 3 weeks).

(4) Reduce remnants of excrescence along with eschar. Repeat treatments until lesions have disappeared. (Many will be gone after second treatment).

(5) Incidence of a recurrence depends entirely upon original causative factors.

(a) In heloma dura the foot gear must be roomy and of suitable material.

(b) In tylomata the foot gear must be roomy and of suitable material, plus a compensation for architectural variances between feet and shoes.

Silver nitrate has been called one of the most versatile of all known drugs; we find this particularly true in chiropody. Over the years we have found the preceding drug and technique of greatest value in the management of heloma dura and tylomata, our greatest headache.

Dr. H. M. Plaster, 316-17-18 Frisco Building, Joplin, Missouri.

Wisconsin Journal, U.S.A.

CONTROL OF FOOT and body odours has always been a vexing problem, and has taxed the resources of physicians and podiatrists for years. During the years 1941-45, while experimenting with the treatment of certain resistant anaemias, it was observed that by using chlorophyll as an internal medicant, we could control these bad foot odours.

Chlorophyll is a blue-green, paste-like liquid soluble in alcohol, and when treated with an alkali forms water-soluble chlorophyllins. These water-soluble fractions are again digested to make them

easily absorbed from the human digestive system, where they are transported directly to the sites of their deodorant action. The exact mechanism of this action is as obscure as that of insulin in sugar metabolism, but from a broad experience we know it works.

A typical example of its action is exemplified by the case of J. W., age 29, a mechanic complaining of severe headaches and sweaty, smelly feet. The headaches were cured by histamine, but not the perspiration of the hands and odorous feet which needed several changes of socks daily. Physical examination revealed soggy feet with callouses on both heels, but good clean skin and nails. The remaining examination was normal. Basal metabolism plus 14 per cent; blood count normal; urine analysis, normal. Treatment consisted of two of Walker's Olodex tablets, each containing 10 mg. of chlorophyllins, taken daily, one in the morning and one at night. After two days his foot odours were entirely relieved, and remained clear for several days after stopping the chlorophyll.

Numerous cases in my own practice plus many favourable reports from other physicians and patients, confirms this report. For best results the Olodex tablets should be used steadily with only short periods of remission.

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NOTES AND NEWS

Children's Foot Health

A FOOT HEALTH EXHIBITION was a feature of the Royal Sanitary Institute Health Congress, held at Scarborough recently. It was a small one, for the instruction of health workers, focused on foot health for children.

A small exhibit on foot care for children and the elderly was also featured in the programme of courses for local authorities attended by medical officers in Belfast on May 10.

Cause of Flat Feet

FOOTWEAR WAS BLAMED as one of the fundamental factors in all cases of flat feet—a tendency to such, by Dr. A. F. R. Finn, Divisional medical officer for South-West Surrey, in his latest report to the Surrey South-West Divisional Educational Executive Committee.

The problem was difficult during the summer months, when most children wore sandals or plimsolls. The majority of parents were quite co-operative on this point, but some children did still quite obviously wear shapeless and ill-fitting shoes which gave no support to the feet whatsoever, throughout the summer.

Chiropodists Marry

MR. C. A. WESLEY, chairman of the Bournemouth branch of the Society of Chiropodists, was married recently at Wimborne Minster to Miss D. E. King, a member of the Society and of the Bournemouth branch.

More School Foot Inspections

AS THE RESULT of a conference on foot health attended recently by Dr. D. J. Cusiter, Medical Officer of Health for the Rawmarsh, Swinton and Wath Urban District Councils, school medical officers in the three areas are to intensify their

inspections of children's feet and footwear.

The parents of children wearing unsuitable shoes will be notified and mothers will be issued with leaflets illustrating correct and incorrect types of footwear for children.

Somerset Children Examined

IT WAS STATED recently at a meeting of the South-West Somerset (Taunton) Divisional Executive that two orthopaedic surgeons and representatives of Messrs. C. and J. Clark (Street) had examined 300 children of all ages in selected schools.

The results of the examination will be published shortly by the principal school medical officer.

Council Veto Chiropody Scheme

A FIVE-MAN DELEGATION from Lanarkshire is to go to Edinburgh and meet officials of the Department of Health following a refusal by the Western Regional Hospital Board to discuss a co-ordinated chiropody service in the county.

The County Health Committee instructed that an approach be made to the board on the subject. The result was a letter explaining the board's attitude and saying that "no helpful purpose would be served" by a meeting between representatives of the board and the county council.

The county council were reminded by the clerk that a draft scheme for the establishment of a chiropody service in the county area had been submitted to the Department of Health, and that the department were now ready to approve "reasonable proposals" by local health authorities to provide a service under the National Health Service Act.

It was further stated that the department had already authorised the payment of

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Vol. II—CORNES AND CALLOSITIES IN THE FOURTH CLEFT, by Henry Trill, F.Ch.S., Chairman, Research Committee, Society of Chiropodists. Illustrated with line drawings. Chapters include: Technique; Etiology; Footwear; Methods of Treatment (Diagnosis, Chiropodial, Medicaments, Padding and Strapping). This highly successful effort at concentration of much information on lesions in a confined area reflects much credit on Mr. Trill's own personal knowledge and his ability to "put over" his subject.—*"Journal of Physical Healing."*

Vol. III—CHIROPODY INSTRUMENTS: Their Use and Maintenance, by C. E. Kemp, F.Ch.S. With 32 line illustrations. Chapters include: The Manufacture of the Scalpel; Hones and Honing; Stropps and Stropping; Cutting Technique; Nail Nippers; Scissors; Files and Rasps; Excavators; Chisels; Forceps. Without any doubt this book may be considered an essential addition to the library of every student and practitioner of chiropody.—*"The Chiropodist."*

Vol. IV—ONYCHOCRYPTOSIS AND ASSOCIATED CONDITIONS AND THEIR TREATMENT, by Ian S. C. Anderson, M.Ch.S., Clinical Teacher, School of Chiropody, Chelsea Polytechnic. The book is a symposium in itself and certainly simplifies instructions on its subject.—*"Dr. Roger A. A. De Bryon-Faes, President of The Universal College of Chiropody, Sydney, Australia,"* It deserves a place on the shelf of every progressive practitioner of chiropody.—*"Journal of the Wisconsin Society of Chiropodists, U.S.A."*

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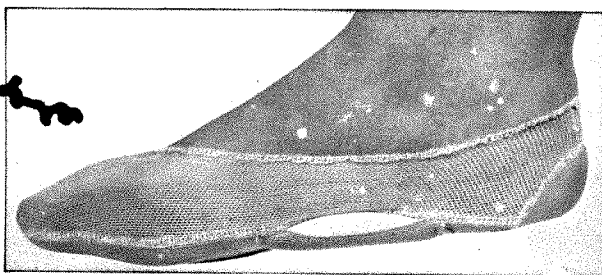
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HON. EDITOR: F. A. DREW, F.Ch.S., M.N.A.Ch.(U.S.A.)

Vol. 19. No. 6. June, 1954

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THE BRITISH CHIROPODY JOURNAL

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LOOKING BACK Twenty-one years ago this month *The British Chiropractic Journal* published its first number as the official organ of the British Association of Chiropractors and throughout its life it has never ceased to play an increasingly important part in the foundation of our profession, in its establishment and development and in its defence as an important factor in the normal well-being of a modern civilised community. It has consistently supported ethical practice, encouraged the extension of educational facilities and demanded a corresponding wider scope of practice, particularly as regards freedom of choice as to the means used to achieve the efficient and effective treatment of foot ailments. It has contributed to the professional literature of the period and in recent years has provided a

window through which British chiropractors have been able to observe something of chiropractic as it is seen through the eyes of chiropractors overseas, whether in France, Canada, U.S.A., Australia or Asia, and through which our many overseas readers have also been enabled to view the position of chiropractic in this country.

Many well-known names have figured in the editorial committees since the first issue appeared in print, commencing with

that talented editor, the late John Bright, and continuing with such names as Franklin Charlesworth, F.Ch.S., J. R. Hall, F.Ch.S., J. McBain Stewart, M.B.E., F. S. Cooper, F.Ch.S., and R. Dick, F.Ch.S.; whilst during the last four years prior to November 1945, when the "British" became a founder-member of the Society of Chiropractors, the

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present Hon. Editor was chairman of the editorial committee and undertook the editorial work.

However, if the British Association of Chiropodists gave up its identity, the *Journal*, thanks to Franklin Charlesworth, F.Ch.S., did not, and by arrangement with the publishers he continued the *British Chiropody Journal* in independent form until December, 1948, when the present Hon. Editor was invited to fill the rôle for a second time.

Throughout its life the same firm of publishers, The Actinic Press Ltd., have, with its competent staff, shouldered a great deal of the back-stage work and many have been the favourable comments and congratulations received on the appearance, quality and presentation of our little journal, especially in its present form.

Our thanks are due to all those contributors and correspondents who throughout the years have done so much to make the B.C.J. what it is, and if one name should be mentioned among so many who merit distinction, it is surely that of our well-known regular contributor, Mr. G. S. Mercer, whose well-informed articles command such keen interest and at times provoke lively controversy.

LOOKING IN The B.C.J. is humbly conscious of its responsibilities towards the public and the profession. We recognise the sincerity of those whose aspirations for chiropody are quite different from our own; we respect the right of those who desire to travel by hansom cab when we desire to fly; we indulge in no personal recriminations and attack no man; but our concern is with principles, ideals, ideas, hopes, aspirations, facts and their presentation, methods. We deplore the disunity which has marred the progress of the profession and retarded it.

We feel very pleased indeed to be in

a position to publish in his issue a number of birthday messages from prominent members of the medical and chiropodial professions at home as well as a number of prominent leaders of our profession in some of the countries overseas where our journal is read with interest. May we take this opportunity of thanking each and every one of them and assure them of our genuine appreciation of their expressions of good will.

LOOKING FORWARD Chiropody must go forward, it must be pushed forward by the dynamic urge of professional opinion harnessed to the public need. We shall continue to stand for the advancement of its status, including state registration of every chiropodist permitted to practice in this country. We shall continue to advocate unity within the profession, the governing of chiropodists by chiropodists within the framework of the law, co-operation with the senior (medical) profession, extension of training and widening of scope of practice. We view the ultimate scope of our profession somewhat on the lines of our transatlantic colleagues, who are still striving to advance towards goals still ahead and aspirations yet unfulfilled. We have a vision of chiropody as an independent branch of medicine, with legal status, freely developing, free from charlatanism, conscious of its responsibilities, filling a real need hitherto not catered for by the medical profession. We see no reason why eventually our training period should not equal that of our colleagues in the U.S.A. and Canada. Agreed it is no vision for the part-time "pin money" practitioner of chiropody, but it is a vision of chiropody—a distant one if you will—but a vision of chiropody as a real profession, and its achievement is a "consummation devoutly to be wished".



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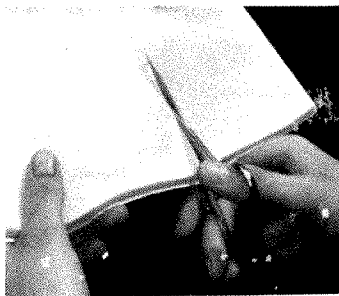
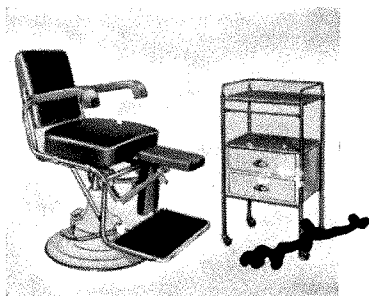
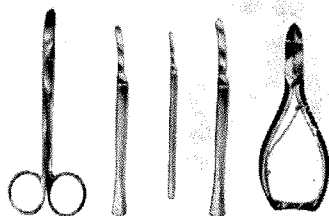
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UNITED KINGDOM

Invaluable Service

From A. Rocyn Jones, F.R.C.S., consulting surgeon, Royal National Orthopaedic Hospital

May I send my greetings to the Editor and publishers of the *British Chiropody Journal* congratulating them on the passing of age of the publication. During the last two decades it has rendered an invaluable service to chiropodists by diffusing professional knowledge and by encouraging the greatest technical attainment in the art; it has also promoted co-operation and a high standard of ethics amongst chiropodists. Since the journal first appeared qualified chiropodists have become organised as a corporate body with their status greatly improved by recognition of chiropody as an auxiliary medical service. The journal was one of the agencies that prepared the ground for this achievement. May its service to chiropody be even greater in the future.

Remedies Made Available

From W. J. O'Donovan, K.S.G., O.B.E., M.D., consulting skin physician to the London Hospital

The anatomy of the foot is extremely complicated and its strength and flexibility are an astonishment to those who have dissected an ankle and its further

joints. Everlasting reputations have been made by the very local anatomical dissections of great men like Dupuytren, Malouonneuve, Ashhurst and Bonnin. Some reputations are still to be made by studies such as the *British Chiropody Journal* would gladly advance and publish.

Unhappily with the complicated arrangements of joints and tendons, veins, arteries and nerves there are multitudinous possibilities of local or indeed general illness and pain.

The chiropodist may well be the first person to note with a professional and educated eye a little swelling that gives notice of a clot in a vein that may become detached and a cause of sudden death and a coroner's inquest.

We may be born with foot deformities, we may acquire them and as civilisation progresses and we walk less and wear more and more mass-produced boots and shoes with heels even higher, the chiropodist will be busily employed in minimising the effects of these physiological and functional errors. There are new discoveries in modern medicine; modern remedies and the latest knowledge are all available to the newest student of chiropody if he will read your journal industriously. The dark ways are made plain to isolated and lonely chiropodists by their great and successful annual conferences. I know their interests are well protected by their professional organisations; their standing is established. They have a share and a part in modern medicine and may I,

Years old

through you wish them collectively and personally advancement and success for many years to come.

Preliminary Work

From A. M. A. Moore, F.R.C.S., president of the board of registration of medical auxiliaries and treasurer of the British Medical Association

It gives me the greatest pleasure to send you a message of goodwill on the occasion of the 21st birthday of your journal. During this period there have been considerable developments in the world of chiropody and to-day this specialty stands on a firm professional basis. Your journal has been associated with much of the preliminary work in this field and I am confident that in the coming years it will continue to contribute to the general welfare of those who practise this specialty. It gives me great pleasure to send you my best wishes for the future of your journal.

Congratulations

From J. H. Hanby, F.Ch.S., president of the Society of Chiropodists.

In acceding to your request for a message of goodwill on the occasion of the journal's twenty-first birthday, I do so with a desire to encourage the efforts of those who are responsible for the printed word in our profession.

Chiropody as a craft has an ancient history but as a stabilised profession is of comparatively recent origin. Now that there is ample evidence that further stabilisation will come with legal status there will always be a place for journals which represent the best in professional

life. There is a heavy responsibility imposed upon those who guide the ideals and conduct of the members of a profession who practise the healing arts. This is the responsibility which should be ever in the mind of the Editor and should be the guiding star in his selection of material suitable for publication.

The development and evolution of our profession is proceeding on sure and sound foundations and one will find in searching into the history of our profession, that professional literature of high standing has made and continues to make an important contribution in helping to attain the ideals that all chiropodists are seeking.

Producing a journal is no easy matter and the editor is to be congratulated on arriving successfully at the twenty-first year of publication.

Thankless Task

From D. Stewart Forbes, F.C.Ch., chairman of the Joint Council of Chiropodists.

It is with very great pleasure that I offer congratulations to the *British Chiropody Journal* on having achieved its majority.

I am sure that life in the mid-twentieth century must be as complex, and difficult for journals as for men; it must, therefore, reflect great credit on editorial, and publishing staff, alike, that, after twenty-one years of existence, the "B.C.J." can rightfully claim to be stronger, and more popular than at any time in its history. When, a few years ago, it elected to follow a policy of "independence", it took upon itself one of the most hazardous, and thankless tasks in the sphere of professional journalism; the measure of its success can be judged by its present large, and expanding, circulation.

The profession of chiropody has ha

a chequered past; and it is possible that even greater problems will have to be faced before long, but whatever the future, it is my profound hope and belief that the practising chiropodist will continue to find, in the *British Chiropody Journal*, not only articles of technical, and academic interest, but also, a fearless, and unbiased statement, on all matters of current, chiro-political significance.

Good luck and all best wishes to the "B.C.J."

Presenting the Key

From C. E. Kemp, F.Ch.S., head of Chelsea School of Chiropody.

In the later Victorian era 21st birthdays were occasions for celebration, and occasionally ceremonials of "presenting the key". In this more matter-of-fact era it appears that at some time between the age of fifteen and fifty the individual has reached maturity and is launched on to the grimly serious business of unassisted survival.

If this is true the *British Chiropody Journal* seems to have reached its majority some years ago, and it is much to its credit that it now flourishes because of its own intrinsic worth and also because there are enough chiropodists sufficiently interested in chiropody to pay for a journal.

Quite frequently I disagree wholeheartedly with the editorial views and just as often I feel I would like to see more information on matters concerning the therapeutic aspects of chiropody and a considerable reduction in the matter relating to politics and pseudo-politics. It is, nevertheless, interesting to me to find that I am wrong in my views, and that many chiropodists are interested in the wider chiro-political field; otherwise the magazine would have ceased publication long ago. If one is in a receptive mood, it is stimulating to find that

someone with opposing views still has a large following and in all sincerity I wish your journal further successes and expansion in the future.

Independent Journal Essential

From Franklin Charlesworth, F.Ch.S., one-time editor of the journal.

On the 21st birthday of the *British Chiropody Journal*, may I offer my congratulations on its reaching its majority.

I think it is essential that every profession should have an independent journal in addition to the official organs. I hope the *British Chiropody Journal* will have a long and useful life.

Indebted for Influence

From R. Sahli, M.V.O., F.Ch.S., chiropodist to the Royal Family.

The progress of any profession is greatly helped by an active and free-thinking Press, and I feel that we are all indebted to the journal for its influence in our development.

I look forward to its future, and take the opportunity of sending you my warmest wishes on the occasion of your 21st birthday.

Devoted to Progress

From J. McBain Stewart, M.B.E.

May I, as an old and observant member of our profession, offer my hearty and sincere congratulations to *The British Chiropody Journal* upon the attainment of its twenty-first birthday.

In this I include those who were responsible for its conception, those who have consistently supported it, and those who so successfully maintain its utility, popularity, and independent policy. To me it is the one unbiased publication, devoted to the service, the welfare, and the progress of the whole profession in Great Britain.

It must be gratifying to Mr. Franklin

Charlesworth, and most others associated with him during the hectic days in the life of the late lamented British Association of Chiropodists, and no less to Mr. G. Stanley Mercer, the enthusiastic and indefatigable general secretary of those bygone days, to see this one remaining direct link with the progressive and unselfish policy of that organisation being so carefully nurtured in the hands of the present editor, Mr. Frederick A. Drew; upholding, as it is, the traditional endeavour to attain unity and stability throughout the whole profession.

May the next decade see the dead hand which still rests upon the wheel of progress removed and replaced by good fellowship, harmony and unity. The consequent attainment of due professional status for all legitimate chiropodists, as the culmination to the efforts so far made, is the sincere wish of "Old Mac".

CANADA

Played Vital Role

From Dr. I. W. Kaufman, president of the Canadian Association of Chiropodists.

It is a privilege to congratulate you on the coming of age of the *British Chiropody Journal*.

In doing so, it is fitting that we pay tribute also to the land which enabled Durlacher, his contemporaries and followers to carry forward the researches that were to become the foundation of our profession.

What we in Canada have achieved in furthering chiropody-podiatry could not have been attained without the development of these basic scientific fundamentals—fundamentals which have set the pattern for our profession in your country and ours.

Today, chiropody-podiatry must become more than merely the name of a profession, for in truth, the chiropodist-podiarist has a responsibility to his community that exceeds the treatment he provides to his patients. Chiropody-podiatry must become an integral part of the health education of our respective countries in a time when people are prone to changing living habits and styles not entirely consistent with their welfare and well-being.

For nearly a quarter century your periodical has played a vital role in the dissemination of ideas in our profession. As you now enter upon a new phase of your existence, we shall continue to look to you to advance the cause of chiropody-podiatry by advocating greater interchange of ideas and information between Canada and the United Kingdom; the standardisation of curriculae and of ethics of practice. As a member of the healing arts, our profession looks to the leaders in its birthland to institute various much-needed changes to abridge the great divergence which exists, in some cases, in the educational standards and definition of chiropody and its field.

The highest degree of professional proficiency is contingent upon the carrying out of these things. And in doing so, we, as chiropodists-podiatrists, can be of even greater service.

Again, our very good wish for your unqualified success.

UNITED STATES

A Definite Force

From C. E. Krausz, secretary bibliographical committee, National Association of Chiropodists.

I note that the June, 1954, issue of the *British Chiropody Journal* marks the

21st birthday of your publication. As one of your early subscribers, I would like to congratulate you. Briefly your policies can be outlined as follows: unity within the profession; state legislation; autonomy of chiropody; development of training to broaden the scope of practice; international universality of chiropody as a branch of the healing arts.

With the above platform, your journal will continue to serve as a definite force in the development of progressive chiropody.

Reached Maturity

From M. N. Cupshan, Pod.D., editor of Current Chiropody.

Accept our heartiest congratulations on attaining 21 years of publication of the *British Chiropody Journal*.

The attainment of 21 years carries with it a connotation of maturity. The *British Chiropody Journal* is an exception to this adage since in our opinion it has reached maturity long, long ago.

We wish you continued success and hope that the future may afford us each an opportunity for a fruitful exchange.

Heartly Congratulations

From Dr. W. J. Stickel, executive secretary of the National Association of Chiropodists and editor of their journal.

On behalf of the *Journal of the National Association of Chiropodists* I wish to extend our hearty congratulations to the *British Chiropody Journal* on the occasion of its twenty-first anniversary.

The need for scientific literature in chiropody is ever present, and the responsibility for bringing out a publication of merit rests largely with the editor. Our felicitations to him in his capacity as editor of the *British Chiropody Journal*.

AUSTRALIA

Admired Efforts

From R. A. de Bryon-Faes, D.S.C., president of the Society of Chiropodists.

My colleagues and I are delighted to learn of the majority of the *British Chiropody Journal*.

We have long admired your efforts to bring about an independent, self-governing chiropody profession, and trust that these efforts shall soon be brought to fruition.

We consider that your presentation of educational matter is in keeping with what is expected and desired in a modern scientific publication.

Carry on with your endeavours; and we sincerely hope that we shall have the privilege of writing our congratulations to you on the occasion of your diamond jubilee.

FRANCE

Received Wide Respect

From the Centre des Recherches Podologiques, Marseilles.

The Société de Podologie and the Centre de Recherches Podologiques send their heartiest congratulations to all connected with your journal, on the occasion of its triumphant first 21 years of publication.

It is a most encouraging thing that in spite of difference within the profession, your publication of independent opinion has received such wide respect as to allow you to go forward year by year to this "coming of age".

It is our sincere hope that you will continue to provide this very necessary service to the profession for many years to come.

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BRITISH CHIROPODY JOURNAL

upon its coming of age

BORN TWENTY-ONE YEARS AGO

by Christina C. Cudworth, F.Ch.S.

LIKE every other profession, the work of journalism has become highly specialised. The sifting and establishment of scientific facts about which there may be a conflict of evidence is not always easy. An editor has to show the results of elaborate research, sometimes extending over many years, together with their relative value to a given purpose, in a clear, terse and convincing literary form. It is, too, almost trite to declare that if radical progress has to be made, controversy can rarely be absent from his columns. He indeed is the hub of it. Impartial criticism can never be of the nebulous kind that allows "the idea that all sides in the quarrels of the past were equally right and equally wrong", and thus escape what Lord Acton once told his Cambridge students, "the undying penalty which history has the power to inflict on wrong".

Impartiality then permits editorial criticism of any stated conclusion in which error may be reasonably supposed, and the expression of a personal opinion in favour of an alteration of a minor or major character, or even the substitution of an entirely new alternative. Strictly he is a merchant of facts and comments within a prescribed orbit.

EXTENSION OF PROVINCE OF CHIROPODY

In this connection the opinions of the Editor have always been clear. He did not wish to see the training curtailed, he explained in the March issue of 1951, but rather to add to it local massage, faradism, medical electricity, ultra violet rays, etc., where not now included. He complained that today with longer training periods there were schools

which did not even teach corrective exercises. On the other hand, Mr. H. Trill, F.Ch.S., told the Glasgow Branch of the Society of Chiropodists in an address published in the Journal, that the work possible under the curriculum of our present definition of province, was enough to keep any chiropodist busy. He suggested the definition should be interpreted in its broadest sense. If this were done it would be found to include in the treatment of the corn, diagnosis and all that that entails; consideration of psychology, muscular imbalance, muscular function and body posture, stance, footgear, materia medica, correct padding and technique of paring, palliative and curative strapping, replaceable pads, advice and post-care of the patient; and a thorough knowledge of the whole curriculum.

REGULATIONS BUREAUCRATIC OR PROFESSIONAL

The report of the Cope Committee was published in May, 1951, and in October of the same year the society of Chiropodists extended its period of training to three years. Then in January, 1954, came the edict that so far as the Minister of Health was concerned, while official chiropodists would not be disturbed in their present positions, future engagements would depend upon applicants having passed the qualifying examination of either the Joint Council of Chiropodists or the Society of Chiropodists, after attending a full-time day course of chiropody for not less than two years; or upon having a certificate issued by the Joint Council of Chiropodists or the Society of Chiropodists, certifying they had passed an approved

examination; or that the name of the applicant was included in lists kept by the Minister of Health, the Secretary of State for Scotland, or the Minister of Health and Local Government for Northern Ireland, containing the names of chiropodists who had satisfied them that their training and experience were adequate for employment.

The undisclosed conditions qualifying admission to the Minister's private lists at once aroused an alarmed curiosity. The regulations, however, at most only offered a temporary threat to the scholastic autonomy of the profession. The Journal found it difficult to believe the Minister could have done other than he had under circumstances bristling with such perplexities.

INCOME v. EXPENDITURE

The prospect of expenditure and depreciated currency cannot be fairly divorced from that of income; here again the Journal was able to throw helpful light. Under the Whitley scale of January 31, 1952, a chiropodist of 21 years and over, working under supervision in the National Health Service was to receive £355 per annum, rising by £15 annually to £430. The datum of this assessment may have been drawn from average salaries then being paid in the foot clinics of the big multiple retail firms and of leading industrial concerns, and from a cross-section of the earnings from private practice.

Did the Whitley average properly reflect the smaller purchasing power of the £ compared with pre-war days? In June, 1949, the Journal pointed out that before the war five shillings was a widely accepted fee, while in 1949, instead of having increased to half a guinea to meet the obvious difference, it stayed at 7s. 6d. at the most.

EDITORS OF THE JOURNAL

Mr. John Bright, M.B.A.Ch., well informed in the theory of chiropody and

skilled in its art, was gifted with a ready pen and a style, trenchant, but sometimes light and caustic. He fought doughtily for a national register based on a syllabus of instruction agreed by the majority of the societies. His columns were open to all alike, contained contributions from men eminent in medical science, especially capable of writing on diagnosis of ailments particularly affecting the feet. Articles of constructive or remedial merit he republished as leaflets for wide distribution among doctors, chemists and chiropodists. With a shrewd understanding of the values of good instruments and accessories, he was a familiar figure at trade exhibitions, and introduced the merits of new specialities to the chiropodial world. From its foundation the Journal was a phenomenal success. It was described by the *British Journal of Physical Medicine* as a dignified and forceful publication, while the *Medical World* was equally complimentary of its design and the high tone of its matter.

The country was under the shadow of war when Mr. Franklin Charlesworth, F.Ch.S., became editor. Endowed with great administrative ability he did much by action and pen to bring chiropodial auxiliaries to the aid of the limping soldier. In fact he was the ideal war-time editor. He was for ever seeking the best interests of chiropodists serving in the Forces. Author of text books, principal of an approved school and foot hospital, and a lecturer welcome on many platforms, it was not possible for one of such manifold duties to retain the editorship long. The Journal owed him a great debt of gratitude for unswerving fidelity to its policy.

Upon the merging of approved societies into the Society of Chiropodists, the Journal which had been the official organ of the British Association of Chiropodists, became an independent

When

REPUTATION

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national publication at first under the editorship of Mr. Franklin Charlesworth, F.Ch.S. If before the editorship of Mr. Fredk. A. Drew, F.Ch.S., the affairs of chiropody had been chequered, they were afterwards doubly so. Over-riding all was the impact of the National Health Service upon settled procedures of medical and chiropodial treatment. Pre-war machinery of medical administration creaked under the strain; experimental plans were involving the whole of medical and surgical professionalism; and benefits promised from this vast revolution were alluring. It was soon abundantly clear, however, that unless chiropody bestirred itself mightily, those falling to it would be few and far between. An ailing foot was as much entitled to State relief as an ailing hand or neck. Striking editorials started the crusade, and daily adherents were being won.

Then came the big hitch; societies who resented the terms of auxiliaryship, either inside or outside the National Health Service, rebelled. This conflict occurred while illegitimate chiropody was spreading at an alarming rate, and the need for unity to promote a national register was imperative. The journal dealt exhaustively with the differences of opinion; so much was this the case that in one number, each point was catalogued, and the pro and con, shown side by side.

The journal passed from strength to strength. In 1950 the President of the Society of Chiropodists in Australia wrote that the organ of his Society, *The Australian Chiropodist*, was being remodelled on similar lines. Mr. Drew has an easy fluency, a strict devotion to facts, a mind which finds essentials from a mass of details. He has a problem well leaving not

his views are not always acceptable, his impartiality is unsullied.

CONTRIBUTORS AND EDITORIAL COMMITTEES

Mr. Bright paid great tribute to Miss Freeman and Mr. R. J. Erskine Orr, of Actinic Press, publishers of the journal, for the great help they had given him.

Franklin Charlesworth, F. Stanley Cooper, John R. Hall, and J. McBain Stewart formed the first Editorial Committee in 1942, to be succeeded shortly afterwards by Messrs F. A. Drew, R. Dick, and John R. Hall (re-elected).

In the issue of the *British Chiropody Journal* of August, 1950, Mr. F. A. Drew, F.Ch.S., M.N.A.Ch. (U.S.A.), as Hon. Editor, was unstinted in his praise of eminent medical men who had given valuable aid to our profession.

"Some names are household words with us", he wrote. "For example, Mr. A. M. A. Moore, F.R.C.S., who assisted so much in the days of 'Recognition'; Mr. Rocyn-Jones, F.R.C.S.; Mr. Norman Lake, F.R.C.S.; Mr. Paton, F.R.C.S.; Dr. Anandale Troup, M.D.; Dr. Wm. Beaumont, M.R.C.S.; Mr. Sayle Creer, F.R.C.S.; Dr. A. P. Cawadiaz, M.D., F.R.C.P.; Mr. Alan Todd, F.R.C.S., not forgetting Dr. W. J. O'Donovan, O.B.E., M.D., whose advice of years ago, to first achieve unity within our profession, and then go to Parliament for Registration, stands as much in need of being followed to-day as when it was given."

And so numerous friends and readers of the *British Chiropody Journal* at home and abroad, will assuredly wish it many happy returns of its twenty-first birthday. It has ever sought the good repute of a worthy vocation; fought hard for their ethics, curriculum, province and registration, and brought much learning and light to elucidate vexed scientific and administrative problems.

REMINISCENCES

by G. Stanley Mercer

IT seems almost impossible that 21 years have passed since the late Mr. John Bright and I negotiated with the Actinic Press Ltd. for the production of this journal. At that time I held office as general secretary of the British Association of Chiropodists. I recall how the managing council of that day feared that the Association's funds were far too inadequate to embark upon the risky business of producing a journal on the ambitious lines proposed by Mr. Bright and myself. I can reveal, after all this time, that the risk was not taken. It was the publishers who shouldered the early financial burden.

One of my most onerous duties was to vet all the material of a chiropolitical character. The editor, Mr. Bright, was one of the most forthright and outspoken personalities I have known and this part of his make-up reflected itself in his editorials. Many is the time I have argued with him into the early hours of the morning when I believed the draft of his leader to be too direct or controversial, and only seldom did he give way. In spite of his stubbornness, however, John Bright was a really great editor; it was a sad day for the profession when misunderstandings brought about his premature retirement from the chiropolitical field.

It has been said by many that the liquidation of the British Association of Chiropodists was a major disaster to the chiropodial profession. As I was so closely associated with its direction, a natural modesty prevents me from expressing an opinion about that. Nevertheless, I will go so far as to state that whether its policy was right or wrong it was a full-blooded, healthy

tion, striving always to make progress. It was never still. Through the medium of this journal the Association was able to convey to the profession the doctrines it believed in. Hundreds of chiropodists were attracted to its cause, and whilst there was no easy entry to membership, its strength grew with amazing rapidity.

Often I find myself reflecting upon those happy times when we met at conventions. The dignity of the occasion was strictly observed but a stupid "starchiness", which so often spoils social gatherings of this kind, was carefully avoided. Their attractiveness can best be measured by the fact that an average of 65 per cent of the members attended.

I have been asked to state what in my opinion are the highspots of chiropodial history during the past quarter of a century. The educational advancement of the profession must surely take pride of place. Training facilities have undoubtedly reached a stage of near perfection, thanks mainly, in recent years, to the great work of the Society. The pity is that the present scope and definition of practice is so absurdly narrow as to render much of the knowledge obtained during training useless in practice. Another important highspot worth recalling was the successful opposition to those two or three attempts made to obtain for a small minority a professional status denied to the majority. Thousands of skilled and ethical chiropodists have since benefited by the success of that opposition.

The recognition accorded to the practice of chiropody by the B.M.A. in 1938 was of great importance. Unfortunately the advantages which should have been gained by this achievement have been

thrown away. Those who happen to have followed my writings will know how strongly I feel about this particular subject.

I suppose the Cope Committee investigation and report must be regarded as a highspot, but I cannot bring myself to write enthusiastically about it. No matter what we may think about the report, the fact remains that it was heavily stamped upon.

The growth of the Joint Council of Chiropodists is another highspot of important consequence. Opinions are sharply divided as to the overall policy of the Joint Council, but it has become a chiropodial force and obtained for itself an influence and authority on equal terms with the Society.

The last of the highspots is the official recognition by the Ministry of Health which provides free treatment in the hospital service. This facility is of great value to the public and for this reason

alone the profession must be thankful. But because of the miserable pittance paid to those who operate the service, this can hardly be regarded as an achievement of professional value.

And what of the future? As I see it, it remains in the hands of those responsible for direction. If they are sensible and profit from their past long list of errors, the clouds will disperse. Those of us who keep in close touch with events know full well that the legal protection of the chiropodial profession is not so very far away. As these words are read a feeling of high elation may creep over the reader. But we must be careful not to place too high a value upon them. The advantage of such protection depends upon the terms and conditions applied. That is why the best brainpower the profession must be collected to safeguard its interests. That brainpower will not be found in just one organisation: it must come from both.

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21

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Round and About

by "Vigilant"



CONGRATULATIONS

MY PERSONAL congratulations to the publishers upon the coming-of-age of this journal.

There is a popular but mistaken belief that the Actinic Press Ltd. became the sole owners only when the journal became an independent publication some seven or eight years ago. In point of fact, the company possessed the ownership rights from the very first issue, twenty-one years ago. By contract it was the official organ of the late British Association of Chiropodists, which organisation determined policy and supplied all the content matter.

When the association dissolved, a few years ago, it was generally expected that the journal would come to an end too. The publishers had other ideas, however, and decided to continue the publication in an independent capacity. This decision met with some mild opposition from a minority chiropodial quarter, but the publishers were adamant. The wisdom of their decision has reflected itself in the immense popularity and large circulation the journal now enjoys.

PATHETIC

I AM BEING inundated with letters from chiropodists seeking employment. For the most part they come from those who cannot hold on longer to establish their own private practices. One lady informed

me that she has tried every means to obtain a job—even an application to the local Labour Exchange. She was informed there that they "thought chiropodists had their own channels of obtaining employment". One of the difficulties appears to be location. Most practitioners have their own homes and for that reason must obtain work within reasonable travelling distance. That narrows their scope of opportunity tremendously. However, I will continue to help these unfortunate practitioners all I can; but it is quite impossible to reply to every letter I receive.

CONTINENTAL COMPETITION

THE BRITISH manufacturers of latex foam sheeting and moulded pads, which are now extensively used by chiropodists, will have to look to their laurels. One or two continental concerns have discovered a new process of manufacture. I have to admit that the products they are turning out are far superior to those of our own British manufacture.

THE CHIROPODIST IN INDUSTRY

THOSE CHIROPODISTS employed by industrial concerns seem to be very happy in their usually good remunerative appointments. Yet only relatively small numbers of the great industrial concerns possess their own appointed chiropodist. Is anything really effective being done to educate these concerns to the value of a chiropodist on their staff? I can see no organised effort. Why? When I mentioned the idea to the head of a

large Midland concern he put the proposal to his board of directors and a free chiropodial treatment service for the employees has now been established.

SUBDUED

I DOUBT very much if we shall hear any more of the isolated attempts to form new chiropodial organisations in opposition to the existing groups. The sponsors of these attempts have, I learn, been disappointed by the response. I suggest that they now try to make their peace with the organisations they deserted.

INSUFFICIENT INFORMATION

CHIROPODISTS, particularly some members of the Society, complain that they are not being given sufficient information about probable impending events. They cannot see the point of all the secrecy. Frankly, neither can I. We all know that a good deal is going on behind the scenes and must not expect to see too much before the curtains are drawn. But

let us not be too theatrical about it.

VARIED REPORTS

FOR THE TIME of the year, practices up and down the country are not so busy as they should be. The older established practitioners have fairly full books but the newer practices seem to be feeling the pinch. Money shortage and lack of warm weather is probably the explanation.

APPOINTMENT

MR. SHIPPER has now been appointed general secretary of the Joint Council of Chiropodists. I do not envy Mr. Shipper his task, but I am quite sure he will make a success of this exacting and worrying office. In this particular instance it is not just a simple job of secretarial routine work. It carries with it organising responsibility and some considerable say in policy making. Mr. Shipper has my very best wishes.

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QUERIES

Answered by F.A.D.

POST AS CHIROPODIST

Q *I am a reader of your chiropody journal and do think it a very good one.*

I am trying to get a full-time position as a chiropodist and wonder if you could help me.

My age is 40 and I have 10 years experience of chiropody. I am a member of the Joint Council of Chiropodists.

I was trained privately for three years by one of the late Sir Herbert Barker's assistants, who was both an osteopath and a chiropodist in his clinic, and was in private practice of my own for two years.

I was engaged by the Co. for a period of 42 years and resigned 9 months ago.

Since then, I have been engaged with the British Red Cross Society and hospitals, in giving service to the old age pensioners.

I charge 2s. 6d. a treatment and find the money which I earn is not sufficient to keep me. I should be very grateful if you could help me.—J. R., A.Ch.

A You may possibly obtain a post by answering advertisements or by inserting advertisements in the chiropody publications, or maybe by contacts with local employers who may know you. We should advise you to study and obtain full membership of your association and thus be able to use L.Ch., instead of A.Ch., and if you practise at all on your own account I should advise you to charge an adequate fee and to receive your patients in a properly fitted surgery. A fee of 2s. 6d. per visit will never permit you to do good work and make a living. A practitioner is not likely to be highly valued

at poverty-level fees. In short, get the knowledge and skill by training and study, then charge a professional fee corresponding to your qualification, whether for employers' or for your own account. Naturally, visiting fees, i.e., in patient's home, should be considerably higher than if the patient comes to you.

It is very charitable to do the Red Cross work, but we should like to know which hospitals employ you at such fees instead of paying the agreed sessional or full-time rates.

PHYSIOTHERAPY

Q *Would you please give me the addresses of the Physiotherapists' Association and the Faculty of Physiotherapists, to which you referred in your recent editorial?*

A The Physiotherapists' Association should be contacted at 31 Dover St., London, W.1, and the Faculty of Physiotherapists at the Scottish Physiotherapy Hospital, Glasgow.

SURGICAL HOSIERY

Q *There is in the April issue, quite a lot about chiropodists supplying elastic hosiery under the National Health Service. Can you, please, advise me where and how to apply for admission as supplier? Many thanks.—W. S., M.Ch.S.*

A Re dispensing surgical hosiery under the National Health Service, if you apply to the office of your local Executive Council you will obtain full details and have your application examined and we hope it will be accepted.

If and when you are registered as a supplier under the N.H.S., you will be able to supply against a doctor's prescription which must be accurately worded. You will receive a notice of charges to patients, for public exhibition in your surgery.

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ABSTRACTS

From Our Contemporaries

The Australasian Chiropodist

TO MEET the Minister's pre-condition for State Registration the Society of Chiropodists and the Incorporated Institute of Chiropodists (N.S.W.) are in negotiations regarding their amalgamation and have reached the following decisions:—

That the councils of these two organisations agree to and recommend a merger on the following conditions—

(i) That the constitution of one of the bodies be used;

(ii) That a name be chosen;

(iii) That six members from each body form the Council;

provided that the three medical members of the Chiropody Board of N.S.W. agree to sit on the council of the newly constituted association.

In this manner the three groups would disappear and there would then be only one organisation.

The Institute said that they would be agreeable if the medical practitioners agreed to the proposition. So the Society agreed to meet the medical representatives for discussions.

The representatives of the Society met the medical representatives at B.M.A. House on Thursday, September 17, and the opinions expressed were that it would definitely be to the advantage of chiropodists generally, as well as the medical profession, if the two associations merged on the aforementioned basis. Likewise the medical men offered co-operation and assistance, and state that they would be prepared to sit on the Council just as soon as we can reach an amicable settlement as to the definition and scope of chiropody.

It is now left for the Institute and the Society to finalise the amalgamation.

Journal N.A.Ch. (U.S.A.)

PREPARATORY sterilisation of the hands of the surgical team and of the patient's skin with a 3 per cent Hexachlorophene in pHisoderm reduces the incidence of post-operative infections. A two-minute scrub with this combination of detergent and antiseptic is equivalent to at least a routine ten-minute scrub, find Drs. Dromley S. Freeman and Thomas K. Young, Jr., of McClosky Veterans Administration Hospital, Temple, Tex. Effects are rapid, atraumatic and non-sensitising.

A CASE study of more than 500 children in the nursery revealed that actual flat foot in the new-born infant is nearly non-existent. On the other hand, some degree of calcaneal valgus is present among a large percentage of babies. Roughly, 5 per cent of all babies have a severe form of calcaneal valgus, another 5 per cent more have a moderately severe form, and another 5 per cent have a mild form.

The observation of pronated feet in review of children over two years of age is roughly from 12 to 15 per cent, which suggests more than an incidental relationship between calcaneal valgus and pronated feet only in childhood. Study of the relationship of calcaneal valgus to pronated feet over the last five years, with a review of approximately 350 clinical cases, indicates that there is a definite relationship.

The baby with moderate or severe calcaneal valgus has an external rotation of the legs and thighs as well as a relation of the heel cords and a tightening of the anterior structure at the ankle. He tends to sleep on the abdomen, a position in which the external rotation factor is continued through babyhood, and as he begins to crawl he tends to continue the

calcaneal position of the foot up until the age of weight bearing. These children usually walk later than other children as a result of instability due to external rotation of the entire thighs with the toes tending to turn outward instead of forward. The instability is due to the calcaneus tendency. Weight bearing in this abnormal position results in severe stress being applied to the ligamentous and bony structures of the feet and ankle so that moulding of the bones and actual bony deformity results if correction is not spontaneously present.

Conclusions are :

1. Babies with uncorrected calcaneal valgus tend to develop flat feet at the age of weight bearing due to abnormal stress upon the impressionable foot.

2. Calcaneal valgus is readily recognisable in the nursery and should be corrected before the age of weight bearing.

3. Calcaneal valgus must be recognised in order that effective treatment may be carried out by the physicians who see the new-born, namely the obstetrician, the pediatrician, and the general practitioner. Once bone deformity has developed, treatment is extremely difficult and time consuming.

—C. F. Ferciot, M.D., Lincoln
Orthopaedic Clinic, Lincoln, Neb.

Santé Publique (Paris)

DR. RAYMOND LARICHELIERE, in an article entitled "Le Pied ce Méconnu", says that when he tells a patient to take care of his poor feet even if it means some sacrifice, because in fact, "You have only one pair", he always expects the reply : "But tell me then, Doctor, why have the doctors not given more attention to the feet ?".

He says the public must find shoes to suit the feet and not subject the feet to the requirements of the shoes. The study

of therapeutic measures must be inspired by a great respect for the anatomy and physiology of the foot in action and must more and more direct its efforts towards ambulatory forms of treatment. One must aim at practically complete restitution of the normal function of the foot by manipulation, physio-therapy, re-education in walking, by foot care and hygiene, by appliances, corrective shoes, and by surgery.

The doctors and public must be forcibly fed with foot notions. Those in all countries who are the forerunners of our profession have a great mission to accomplish. The Faculties of Medicine must be impressed with the importance of the matter. Medical journals should open their columns to chiropody (as indeed "Santé Publique" does), and the film, radio, and television appear to be suitable modern means by which to inform the public if only we will give ourselves the trouble of preparing the matter for broadcasting. Do not forget that 80 per cent of human beings suffer from foot troubles."

Chiropody Record (Chicago)

CHILDREN in to-day's practice should be the number one objective in the field of chiropody. The "great baby boom" that has been going on for the past thirteen years should eventually prove a boon to professional men and it behoves our profession to publicise the need for greater attention to children's feet.

Families are on the increase as each decade passes. It is estimated that by 1960 there will be 180 million persons in the United States. Larger families are in the offing. The number of fourth children being born this year will exceed 1940's by 61 per cent. In the next 10 to 20 years, as the babies of the "boom era" reach marrying age, there may be a new population expansion that will dwarf the present one.

NOTES AND NEWS

Elected Councillor

MR. JOHN S. THOMSON, Aberdeen footwear specialist and chiropodist, was elected a national councillor of the Incorporated National Federation of Boot Trades Association at their annual general meeting held in Clacton recently.

Revised Registers

THE BOARD OF REGISTRATION of Medical Auxiliaries has published revised registers of chiropodists. Copies of the registers are supplied free to medical practitioners on application to the board at British Medical Association House, Tavistock Square, London, W.C.1.

Chiropody Extension Recommended

AN L.C.C. DEPUTATION will ask the Minister of Health for an extension of the chiropody service provided by the council in London. This move was recommended by the L.C.C. Health Committee and accepted by the council.

The Health Committee stated in a recent report that the L.C.C.'s chiropody service is "inadequate and unbalanced" in some parts of London, particularly in North Hackney, Stoke Newington and Finsbury. The committee also pointed out that the extension of the service is a logical development of the functions of the local health authority.

Medical Auxiliaries Dinner

THE FIRST DINNER of the Board of Registration of Medical Auxiliaries was held at Apothecaries' Hall recently, with

In proposing the health of the board the president, Mr. A. M. A. Moore, in the chair.

Sir Russell Brain, P.R.C.P., said that medical auxiliaries were an integral part of medicine and should not be looked on just as additions to medicine. There must be co-operation, not only with the profession, but among themselves.

In his reply Mr. Moore said that the

main function of the board was to publish sectional registers of each of the qualifying bodies registered with it, and it was hoped before long that a comprehensive register would be brought out. In addition to this, one of the main objects of the board was to promote legislation for the establishment of a statutory register.

The health of the guests was proposed by Mr. John Hanby, president of the Society of Chiropodists, and responded to by Sir Heneage Ogilvie.

Foot Health Week

A FOOT HEALTH week organised by Gloucestershire County Council will be held in the South Gloucestershire area in September.

A foot health exhibition will be opened at the Manor House, Frenchay, on Sept. 13, and held in a mobile van. It will include an exhibit on Foot Health Education for children, foot care for the aged, and a model shop for demonstrations of shoe fitting.

Schools Chiropodists

A FULL-TIME schools chiropodist may be employed by West Ham, London, Education Committee.

Chiropody Aids Engineers

A PART-TIME CHIROPODIST is helping the medical staff to treat a reputed average of 200 employees per day in the surgery of Babcock and Wilcox Ltd., the Scottish engineering firm.

Training Needed

SHOP ASSISTANTS should be trained to fit shoes and pass examinations in the art of shoe fitting, said Mr. S. Tennant at a recent meeting of the Southport branch of the Boot Trades Association.

Mr. G. Roberts, M.Ch.S., said that between 80 and 90 per cent of British people suffered from foot troubles and that "the best thing that could be done

would be to spread the gospel of anatomically correct fitting shoes."

Mr. C. J. Hankinson

THE FUNERAL took place recently of Mr. C. J. Hankinson, M.Ch.S., of Warrington, Lanes.

Mr. Hankinson was a chiropodist on his own account. He was educated at Runcorn Grammar School and studied at Manchester Foot Hospital for membership of the Society of Chiropodists.

In Inestimable Service

THE MINISTER OF HEALTH, Mr. Iain Macleod, said recently at the annual meeting of the County Councils' Association that there should not only be closer co-operation between those responsible for the operation of the health and welfare services and the general practitioners but also for the fullest opportunity to be given for voluntary effort to make its contribution, especially in helping to solve the growing problem of the care of old people.

He said that he would like to see better use made of the services provided by the local health authorities, in order to relieve the hospitals of some of the burden now falling on them.

In connection with the care of old people the minister said that local authorities fostered old people's clubs and some private chiropody; an inestimable service for literally keeping old people on their feet and one which could not at the present time of financial stringency be fully covered by public funds.

Appeal to Chiropodists

AN APPEAL to Wandsworth chiropodists to set aside one afternoon a week to attend to old-age pensioners at a reduced rate was made recently at the annual meeting of the borough's Old People's Welfare Council.

A chiropody service for old people is being started by the council in Putney.

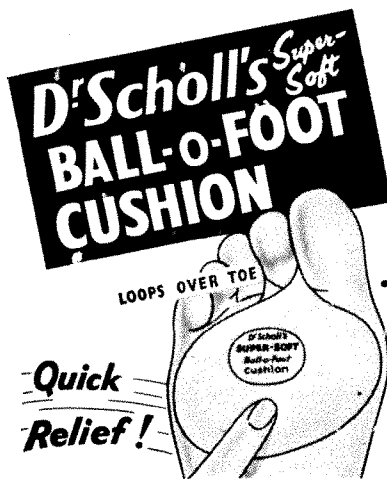
Equipment has been presented by Putney Rotary Club and the service will be run by the Red Cross.

No Home Visiting

THE MINISTER OF HEALTH cannot "in present financial circumstances" allow Leeds City Council to provide the services of a chiropodist to visit old people in their own homes. Such was the reply to the council's recent application.

Mr. Macleod suggested that the council should ask voluntary organisations to carry out an identical service. The reaction to this in Leeds was that these organisations would charge the council as much to run the scheme as it would cost the council itself.

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The engagement of persons answering advertisements must be made through a local office of the Ministry of Labour, or a scheduled employment agency, if the applicant is a man aged 18 to 64 inclusive, or a woman aged 18 to 59 inclusive, unless he or she, or the employment, is exempted from the Provisions of the Notifications of Vacancies Order of 1952.

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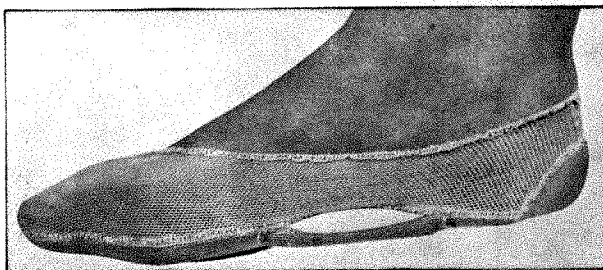
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UNSOLVED PROBLEM As in the youth of the individual so in the youth of a profession problems are constantly presenting themselves for solution. One of the oft-discussed problems of the profession is that of the wide variation in the scale of fees charged to patients by practitioners of all grades. This problem, perplexing enough at all times, is rendered more acute by the influx of numerous unrecognised practitioners among whom there are so many part-timers nibbling at the fringe of chiropody for uneconomical pocket-money fees. Only the law can effectively counter this invasion by outlawing all but legally approved chiropodists; in other words by the long hoped for State Registration.

There is no doubt, however, that even among properly trained chiropodists there is considerable confusion in economic matters and there is found only too often a tendency to underestimate the value of efficient service. There is a grave danger in many cases that the acceptance of too low a fee for a job well done may lead to the economic necessity of doing a job less well within an inadequate time limit in order to re-establish the financial equilibrium between outgoings and income, and thereby to develop the "Cut and come

again" or "In an' aht" type of clinical practice. There is therefore bound up in this financial problem a question of ethics, both as affecting conduct between chiropodist and patient, and between chiropodist and chiropodist.

PROBLEM UNIVERSAL The whole problem is bristling with difficulties and is one which is experienced not only by chiropodists in Great Britain but by those in other countries too in one form or another. For example, in the U.S.A. Dr. D. C. Rasmussen said recently: *The chiropodist must feel justified in charging the patient's fee. He should set his fee on a valid business-like basis—and the patient must be informed that this is so. The chiropodist should adopt the local fee schedule and avoid scaled fees based on ability to pay.*

The Wisconsin Society of Chiropodists' Committee on Economics recently reported on "fair and adequate fees" and sent to their members a schedule of "recommended chiropodial fees" which was based on a minimum fee of three dollars with a gross fee at the rate of ten dollars per hour for routine service. What such terms are precisely intended to convey does not immediately concern us; the point is that the problem is a

monster which may equally well be met on the shores of Lake Michigan or on the banks of the Thames.

In Australia the Society of Chiropodists and the Incorporated Institute of Chiropodists (N.S.W.) renewed their agreement for a minimum of 10s. 6d. per visit as a basic charge to patients.

You know, the Australians are folk to be watched. They get things done; and they are to be congratulated on their ability to see essentials, to sink their inter-society differences where these are found to impede progress, and to keep their eyes on the task of creating a profession under the umbrella of legislation. For them the healthy strength of the corporate body with all its limbs intact and working for one cause rather than the dismembered body with its weakened trunk in splendid but powerless isolation.

In this country chiropodists are always worried by the problem; in the June issue of the *Chiropodist* a correspondent writes pointing out the need for raising fees to correspond with rises in the cost of living and asking for guidance from his Society, whilst the Political Correspondent of the *Chiropody Review* in a recent issue writes a two-page article entitled "What Is Your Fee?" and deplores the fact that: *Very often the fee is more in the nature of a nominal sum than a charge for a service rendered and that As large a variance in fees can be found among practitioners who have undergone a course of training at a school, as among those . . . in practice after a course in chiropody by correspondence.*

CAN IT BE SOLVED? One may say that the whole profession is intimately concerned with this fee problem and it appears to us that so far as this country is concerned it is a problem which cannot be dealt with effectively off-hand by

any dictates or advice from committees or councils. Such advice at the present moment would be based on insufficiently co-ordinated evidence. It appears to us that what would be useful at this stage is for members of both the Society and the J.C.C. to hold joint meetings in all administrative areas and that this question of fees should be frankly discussed and all cards put on the table, examined with sympathy and understanding, and a genuine attempt made to agree on a schedule of minimum fees to be charged by all chiropodists throughout the area concerned, with—of course—freedom to charge more at their own discretion. Copies of such schedules should then be sent to the headquarters of both organisations and would form reliable information on which mutual decisions could be arrived at as to any desirable advice or action needed to bring up to standard the indicated backward areas. The essential point is that any minimum fees agreed upon should be calculated on an economic basis and on a standard which, given a normal week's work, would provide a professional man and his family with a dignified existence.

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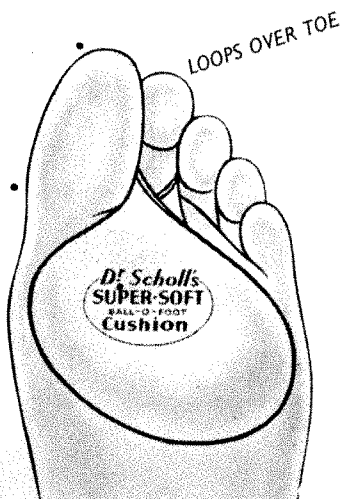
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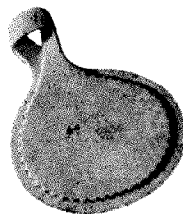
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THE LOWER LIMB IN BALLET TRAINING

by R. Watts, M.Ch.S.

IT has long been my belief, possibly because of an interest in the art form considered, that the chiropodist can play an important part in the recommendation and examination of children preparing to take ballet classes and in a consultant position while the child is under training. When we consider that approximately 50 to 60 per cent of the country's girls of certain financial classes take at some time in their lives ballet lessons, I feel that we as chiropodists should understand a great deal more about the methods and physiological changes inherent in a series of dancing classes. Besides examining children's feet prior to their commencing classes with a view to advising parents regarding suitability, there could be occupied a position whereby our combined knowledge of ballet training and detailed anatomy would assist in the prevention of the deformities frequently developed during dancing, which cause the condemnation of this form of occupation in later life.

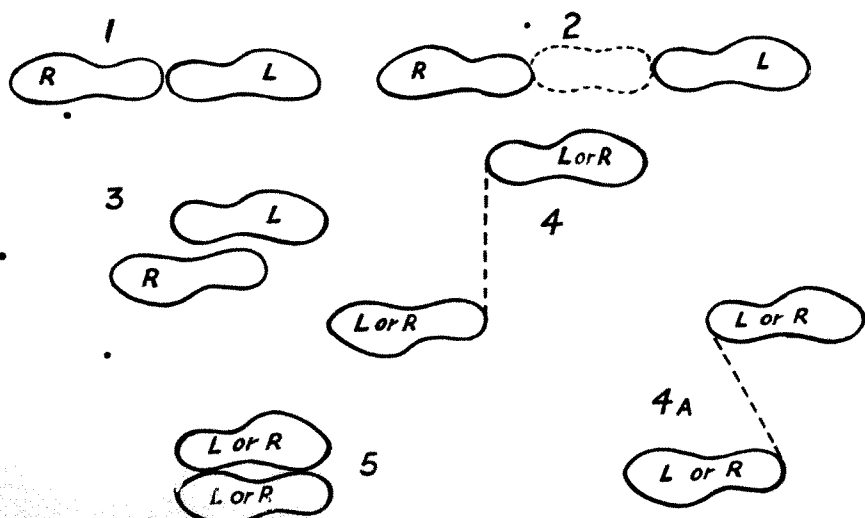
Ballet is a specialised and detailed style of dancing and because of the strains imposed upon the body can, with unsuitable training, cause more deformities and unnecessary disorders, many of them not apparent until later in life, than any style of dancing known. For this reason the teacher is in a position of great responsibility, and because in many cases these responsibilities are not maintained, so the lay public has considered ballet training to be injurious to the feet. In fact, it should be known as one of the finest physical and mental exercises, available for young people, at times aiding in the correction of certain mild deformities. Besides providing an even muscular development, it forms a sense

of discipline and mental control that is invaluable to the formation of personality in later life.

The teacher must, therefore, be all-important, and as with all else there are the bad ones and the good ones. The best, at our leading ballet schools, can detect anatomical deformities and predict future development by instinct without any detailed anatomical training, whilst the worst care very little for the future of the child but concern themselves with pushing their pupils through more and more examinations, often before they are either physically or mentally developed to sustain the strain of such advanced movements. The teacher is not solely to blame; frequently it is the mother who pushes her child through advanced movements, thinking that examinations are the sole criterion of dancing ability. The position of the chiropodist when talking to the parents should always be to restrain and restrict, remembering the points to be mentioned later in this article.

To understand fully the general abuse apparent in poor training, it is necessary to have a fundamental idea of the positions taken by the lower limb for commencement and finish of all classical movements. These positions are held for all barre exercises and tend to become a "natural" position.

In the early part of the seventeenth century, when dancing was performed by the king's courtiers and not by professionals, the French cavaliers wore heavy bucket-shaped cavalry boots. To walk in these it was necessary to swing the legs out and round in an arc, thus avoiding the wide boot tops. As the



Fundamental positions of the leg in ballet

foot came to the ground the toes were well turned out, this being considered a point of style. Whether this is fact or fiction we cannot be sure, but we do know that a strong turn-out became the hallmark of good dancing, and because this position was efficient — it being impossible to perform the *passe-pied*, *sarabande* or *minuet* without it—it has formed the basis of what we now call classical dancing in ballet. Petipa, the father of the present dance system, based his whole conception on five fundamental positions of the leg, from one of which positions all movements started and finished. These positions are known numerically as in the diagram.

It becomes apparent at once that the strain from this abduction on the medical ligaments, and in fact the whole medical aspect, is immense, unless the position is taken correctly. The safeguarding against a complete valgus collapse should begin with the first lesson, where the guiding principle of any teacher is :

- (1) To see that the foot holds the ground.

- (2) That all rotation takes place at the hips so that the alignment of the knee, leg and foot never alters. ("The foot has no independent existence." — Madame Celia Sparga.)

If, because the pupil is advancing well in her work, she is encouraged to turn the femur out too far, the muscles are probably not sufficiently developed to control this turn-out. Thus the greater part of the abduction takes place at the foot and ankle with consequent pronation and bulging of the peroneals. Once this has occurred it is difficult to make any improvement later on and the child loses the required strength and control of her ankle.

It becomes obvious that such a rotation must only take place gradually, the individual child's development and training constantly being considered.

The whole basis of a dancer's training derives from her correct position at the barre. Reflex control must be such that she takes up a position by absence of movement, i.e., while movements are

being performed, the rest of the body takes up the correct position by reflex action, the hip muscles hold the pelvis locked and advanced, the knees are locked and the muscles of the leg and foot are evenly balanced. She is in fact firmly placed because she is not concentrating on turning out only her feet but also her hips and knees. Thus the feet turn out automatically without any pronation or valgus rolling.

From these opening remarks, the reader will see how readily permanent injury can be caused by inattentive teaching.

ABUSES OF TRAINING The commonest fault, originally in the parent but accentuated by the teacher for economic reasons, is the acceptance of children at too early an age for pure ballet teaching. A child should not commence ballet before the age of eight to ten. Before that time the bones are not sufficiently ossified to withstand the strain, nor is the knee strong enough. Between eight and twelve a limited amount of work can be allowed, remembering all the time that ballet is essentially an adult conception of movements, the child being less co-ordinated and sophisticated than the grown-up. Before this age they should only indulge in pre-ballet dancing, which is based on ballet and incorporates the best of basic balletic exercises—correct stance, breathing, etc., with development of flow and rhythm.

The second abuse of training, the execution of advanced movements too early, I dealt with in the introduction. Concerning this, it becomes obvious from a glance at the diagram that it is better during the early stages to practise exercises from a modified second position than to push the child into a third or fourth position which will disrupt the whole function of the foot's inner segment.

Pointe work is of course a difficult problem. All mothers like to see their children prancing around on their toes and it requires the most painstaking advice to warn them of the future dangers of such work unless the child has had at least two or three years' preliminary training, before the age of 9—12, preferably with daily supervision. With all ballet it is quite obvious that ten minutes' training every day is infinitely preferable to an hour a week. No hard or fast rule can be laid down regarding pointe work, although it is generally inadvisable for a girl who is not doing daily practice to attempt pointes at all.

Some mention here should be made about the shoes used in ballet. Whereas the unblocked slipper normally used in early ballet training is a good thing in that it allows freedom of movement in the foot and leg and by its light structure allows the ground to act as a stimulus to the intrinsics, it has a drawback. If the child has a tendency to hallux valgus, or slight metatarsal varus, the shape of the shoes is such that there is a cramping of the fore-foot and thus an inclination to aggravate the condition, unless the pupil is taught to exercise her adductor hallucis by adducting the hallux against the shoe.

When the child comes into more advanced training, care should be taken to see that she does not wear the blocked slipper exclusively because the strength of the sole is such that very little body weight is taken by the intrinsics and there is a tendency for the long flexors to be used to the deterioration of the brevis muscles. Disuse breeds weakness; in this way the strong flexion of the longus muscles produces an arch at the ankle which, although beautiful to regard, is weak in action. All these remarks especially apply to the exaggerated block often used in America.

PHYSICAL EXAMINATION OF LOWER LIMB

We now pass on to the matter of the suitability of a child brought up by her parents to commence ballet classes. The whole matter must of necessity be one of degree, because depending upon a number of factors so will depend your judgment.

First, are the parents' ambitions for the child such that they hope she will take up dancing professionally? If so, we can brook very little deficiency at all; the child must not possess any of the bad characteristics mentioned in this section. If the mother wants her to commence dancing only for general physical and mental development, well and good. There are but few disorders that should bar her child from such exercises, although it is important to find out if lessons are to be given at school, through private tuition, or from a reputable dancing school, and also the frequency and length of each lesson. All these factors must form your foundation for any opinions formed from subsequent examination.

GENU VARUM ET VALGUM Concerning bow legs, genu varum, and knock-knees, genu valgum, marked degrees of this deformity will not usually endure ballet training, although minor degrees may even improve due to a tightening of the thigh muscles. In these conditions the importance is for the teacher to recognise to which of the two groups the pupil aspires and alter the training accordingly. As Noverre said, "Is it not essential to lead them to the same ends but by different roads?" Mild degrees of genu varum and valgum are known in ballet as *arqué* formation and *jarreté* formation of the legs respectively, and it is inadvisable to give the same exercises to dancers who have these differing formations.

The Arqué formation or mild bow-legs.—One cause of this condition is a bad position of the legs due to an inversion or medial rotation of the femur with over-extension at the knee joint. The easiest way to identify this type is to get the child to rotate outwards at the hip with the feet ahead; thus the leg rotates on two fixed points and loses the varum deformity. Providing the over-extension at the knee is not too great, some improvement can be gained from ballet due to muscular control and improved postural reflex, but over-extended knees are a weakness and always permanent.

The dancer with this *arqué* formation of the legs is usually of a stiffer, more strongly built type, and generally because of this she needs plenty of encouragement. The stiffness may make many exercises and movements difficult to perform, but once the joints have loosened with suitable exercises, the good musculature can prove a great asset. The long flat feet in girls causes difficulty in rising on pointe, but those strong feet are an asset in jumping and elevation, giving the dancer what is known as "ballon". This type must concentrate on stretching exercises and attempt to eliminate the bowing by rotating the leg out.

The Jarreté formation or mild knock-knees.—This type of child is usually ligamentously lax, although some degree of knock-knees is seen in most young girls, due to the wider pelvis. Although counter-action can be applied by contraction of the thigh muscles, there is always a great strain thrown on the medial ligaments of the knee and foot. As she advances in training, rotation of the leg will appear easy because most of the turning is occurring at the ankle joint. This type of condition usually shows considerable improvement, and often a cure, if given the right exercises.

Although she will want to perform loosening exercises—as grand battements (raising a straight leg as high as possible in one strong movement), “splits”, etc.—she must practise just the opposite. Strengthening movements to control the loosely-knit joints—rond de jambes (a strong circumduction of the lower leg holding the thigh horizontal and steady, or the same with the whole leg), pliés, etc.—which will hold the leg straight and disguise the loose ligaments by perfect muscular control.

HALLUX RIGIDUS This is a crippling condition for a dancer and can only deteriorate; incipient cases should not even be encouraged to attempt pre-ballet dancing.

Following this, it is important to note carefully the over-highly-arched foot, hypermobile, unstable and with long toes and metatarsals. This type requires greater preliminary training and even then does not make a satisfactory foot. It would be impossible for such a child to take up dancing professionally. The ideal type of foot is one with a metatarsal formula $1=2=3>4>5$, with short toes and a not too squat appearance combined with unrestricted dorsi-flexion at the ankle. A tight posterior group is one of the worst faults with which to cope and it is up to the chiropodist to decide if it is a muscular or fibrous tightening, then instituting the requisite treatments. The great danger is that a plié (knee bend from one of the basic positions mentioned earlier) will cause a valgus roll in an attempt to keep the heel down.

HALLUX VALGUS Has been mentioned in relation to ballet slippers. If the condition is marked it will tend to worsen by ballet training and will never support the body on full point, although mild cases may improve by adduction against the shoes.

HAMMER TOES Can become worse due to ballet slippers and cases must be left to the discretion of the examining chiropodist.

As I remarked previously, the whole matter is one of degree and if there is any doubt it is better to advise the child to commence classes once a week and go on to more classes if no untoward signs appear. The mother's role must be to restrain and see that her child does not attempt work too advanced for her physical capabilities.

ACUTE DISORDERS ARISING On the whole, dancers' feet are comparatively free from troubles, except strains. Verruca Pedis and fungus infections are no more common than other age groups generally.

Sometimes the child complains of a non-traumatic pain in the foot often due to too little work by the short flexors in blocked and supported slippers. This can be overcome by the performance of many battements tendus which are movements designed to exercise the intrinsic muscles. The exercise consists of a strong extension of the leg without tilting the hips and without removing the toe from the floor. Commencing in 5th position, the working leg slides out with a slight pressure on the floor. The medial border is pushed well forward and the whole foot fully arched, the whole movement in and out being very firm and precise allowing for full contraction and stretching.

If the young dancer allows her ankle to pronate on pointe, there may be a slight teno-synovitis of the tibialis posterior. Excessive pointe work with insufficient pliés and fondu movements lead to a bursitis in the achilles tendon. This condition is especially noticeable when a company has been on tour and the spectacular use of full pointe has not

been compensated by sufficient barre exercises.

On the whole the foot may look unsightly, but these calloused areas (especially on the plantar surface anterior to the metatarso-phalangeal joint caused by pressure on half-point) are usually protective and safer left alone.

Cynchocryptosis tend to keep recurring due to excessive pressure on that part of the toe combined with the hyperhydrosis that follows such sustained efforts.

The shape of the dance shoes may be the cause of the H.M. at the base of the 4/5 cleft which is reported (Gallocher) to be quite common among dancers.

Concerning padding, if such is necessary, the dancer's shoe adapts itself to sponge-rubber padding fitted on to the insole. With the stringent hygiene necessary to dancers, it is useless to expect them to keep padding adhering to their feet for any length of time.

To finish, I must repeat once again, in the examination any opinion must depend on the degree of the deformity correlated against the future activity of the child. Bad deformity rules out excessive dancing, mild deformity in the hands of a sound teacher may improve, but if mishandled can lead to future trouble that will blacken the name of ballet in that woman's mind. The responsibility lies first in the hands of the chiropodist and then with the parent and/or teacher.

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THE WEAKFOOT CONCEPT—Part IV*

by L. F. Schreiber, F.A.A.C. (Hon.), F.A.C.F.O., and
H. W. Weinerman, D.S.C.

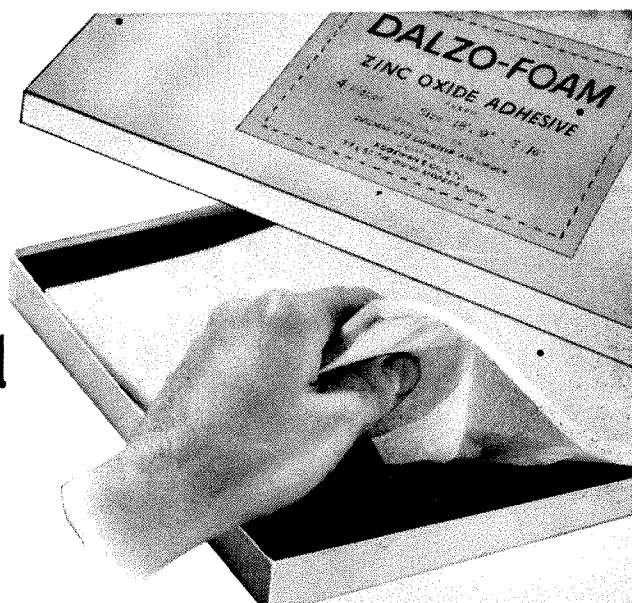
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the tremendous strains and stresses to which the foot, as a unit, is subjected. At the same time, this allows greater freedom of motion to the forefoot as the

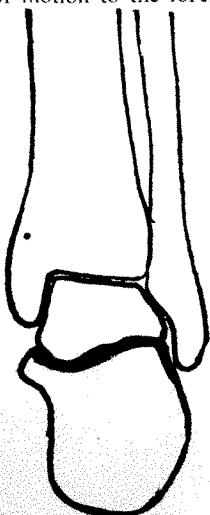


Fig. 1. Illustration of the quaternary (calcaneum, talus, tibia and fibula), a structure possessing great stability to meet all normal strains and stresses. Note the wave-like process of the subtalar articulation (indicated by the heavy line), a feat of engineering by nature to prevent fracture or displacement of the talo-calcaneal articulation. (Posterior view.)

hinge-like articulation of the ankle joint executes its excursion. On the other hand, the forefoot is under the anatomic disadvantage of acting as an appendage to the powerful leverage demands of the rearfoot, in addition to its own delicately specialised functions of pivoting and balancing the body and adding spring to the step while propelling the weight forward over the fulcrum at the metatarsophalangeal articulations, for all of which it is admirably adapted.

It is obvious that the quaternary posses-

ses tremendous stability, while "pronation" (extensibility) is a natural by-product of this skeletal combination. Yet, there is sufficient flexibility of the forefoot to counteract interference with its free action in the performance of highly intricate functional movements to sustain the integrity of the foot against shock or fracture under ordinary conditions.

Furthermore, one must not overlook the fact that the rearfoot has a far greater integrity and defence against disalignment than is the case with the forefoot, since the latter is better adapted through its semi-flexibility to guide the foot to a safe landing at the completion of each step in locomotion. In that sense the forefoot is analogous to the landing gear of an airplane, while the rearfoot is like the rigid cabin which it sustains and guides. The heel-toe manner of forward progression does not influence this relation, contact of the heel with the surface being of momentary duration while the forefoot bears weight long enough to assure propulsion of the body and to exert a "braking" action.

Engineers²³ have shown by experiment that the fascia lata (covering the thigh), the strongest layer of the body, possesses a tensile strength of approximately 1,476 kg. per sq. cm. or 20,959 lbs. per sq. inch of cross section. The plantar fascia is the strongest single structure of the foot. The estimated tensile load of this fascia is roughly 35 kg. in a person weighing 60 kg., standing on one foot, with weight relaxed. Since it averages 15 cm. long and about 0.5 sq. cm. of cross section, the maximum elongation under stress cannot exceed 1.4 per cent. This means an elongation from 15 cm. to approximately 15.21 cm., allowing for sagging of the head of the talus of close to 0.1 cm²⁴.

The shock-absorbing property of the foot therefore assumes only an academic interest if the range of its flattening and

recoil power is limited to approximately 0.1 cm. It is noteworthy that the sudden application of extreme tensile violence to fibrous structures, beyond their normal tolerance, will not result in a rupture unless preceded by a cortical avulsion fracture of bone at the point of fibrous attachment, indicating that bone must give way before ligaments will tear under conditions of great stress. Bone is capable of bearing compression stresses while fibrous tissues are built to withstand tensile stresses, in consequence of which the arched structure of the foot cannot flatten to any appreciable degree without violence or bone disease.

Thus, it is clear that pronation represents an optical distortion of what is in fact a natural phenomenon in the complete cycle of static and dynamic forces alternating between limited active extensibility and passive contractibility of fibrous tissue during the act of locomotion. Nor is it difficult to perceive that the extremes of rigidity or flexibility of the arched

structure are absent during both phases of the cycle.

We can do no better than present timely abstracts from the famous research team of Schwartz and Heath²⁵ on the problem of dealing with those common biomechanical disabilities of the foot having little or no relation to the variations in architectural make-up, such as the weakfoot type, yet requiring conservative treatment to provide symptomatic relief and to restore functional efficiency demanded in the pursuit of daily tasks:

"It becomes evident that we are to deal with variables of those clinical problems most frequently seen. The anatomical definitions of function have suggested a simple and direct explanation of the cause and treatment of such common complaints. However, time and an examination of large numbers of these structures deny such assumed regularity. The inherent variables unite to form a structural unit which serves the function

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of locomotion. *The feet have, therefore, in common with other structures, a range of variations within the classification of normal.*

"The inherent weaknesses of the human foot have long been recognised. Its potential strength and methods for best utilising prevailing structural advantages have not received equal consideration. As long as information is drawn only from visual observation of the living foot and from anatomical studies of the static structure, we shall fail to reach a maximum understanding of the requirements of the human foot for its most efficient functioning. Until recorded evidence capable of quantitative measurement and interpretation is more widely applied, therapy, both conservative and operative, must continue to be instituted and evaluated empirically. *This is particularly true in the structurally normal foot, which is dependent upon conservative treatment for the alleviation of pain and fatigue and for the restoration of functional efficiency.*" (Authors' italics).

ARMY FOOT SURVEY To indicate the vast amount of time and work that has been put into the study of the skeletal structure of the human foot, and to deduce therefrom what has been largely accepted as a theoretical means of differentiating between the normal and the morphologically pathognomonic, the outstanding example of the twentieth century is to be found in Dudley J. Morton's book, *The Human Foot*, published in 1935. The deductions of function, on the basis of structure, have always seemed to provide a highly fascinating means of approach to serious investigators of the foot. The nominal admission, on the part of investigators, of the existence of Wolff's law seems to bear little application to the foot in so far as primordial function is concerned. Instead, these investigators usually present artificial and idealised hypotheses on normal foot

function and morphology which could be more readily applied to a manikin than to man. Ironically, the foot is the sole organ of the human frame to be accorded such completely mechanised study without benefit of accepted physiologic laws commonly applied to other parts of human anatomy.

Carrying this point to its logical conclusion by way of example, and as a practical illustration of the relatively great importance attached to the Morton syndrome in the field of orthopaedic work, we present abstracts from Harris and Beath in their highly illuminating observations and interesting statistics gathered from the Canadian Army Foot Survey⁶ in which they produce concrete evidence to shatter the Morton theory in actual practice. Referring to the short first metatarsal, they continue:

"... In actual fact, the problem has never been submitted to adequate study, either by Morton or by others: and there is nothing in *The Human Foot* concerning the association of the short first metatarsal with foot disabilities which might not be the result of coincidence.

"... The findings of this Canadian Army Foot Survey in respect to the short first metatarsal are of considerable interest and importance, the more so since they do not support Morton's hypothesis.

"... At the enlistment centre, 3,619 men were examined by precise methods. Of these, it was possible to follow 1,391 during their military training and to determine the functional capacity of their feet. From such observations, important conclusions have been drawn in respect to the alterations in function which result from foot defects and abnormalities, including shortness of the first metatarsal.

"The method adopted by Morton for determining the length of the first metatarsal in relation to the second (the position of the most anterior portion of the head of

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the first metatarsal in relation to a line tangent to the head and at right angles to the axis of the second metatarsal) is open to considerable error, depending upon the position of the metatarsals in respect to varus and valgus.

FINDINGS *Short first metatarsal.* "In 2,878 feet the first metatarsal was shorter than the second by 1 millimetre or more.

"In 2,693 feet the first metatarsal was longer than the second by 1 millimetre or more.

"In 1,596 feet the first and second metatarsals were of equal length (within 1 millimetre).

"These figures demonstrate that shortness of the first metatarsal is common, but so also is overlength of this bone. The most common state is equality of length between first and second metatarsals (1,596 cases or 22 per cent). The majority of the remaining cases are within a few millimetres of equality, suggesting that this represents the normal for most feet.

"If we arrange the measurements with respect to individual soldiers, we find that in 1,282 men the first metatarsals were shorter than the second; and in 2,337 men the first and second metatarsals were either of equal length or the first metatarsals were longer than the second.

Association of short first metatarsal with pes planus. "Morton's contention that shortness of the first metatarsal induces pronation of the forefoot and depression of the longitudinal arch makes a study of this association important. It is possible to correlate the two factors from the data of the Foot Survey, and this has been done for several relationships. *In all of these studies, there is no greater incidence of pes planus or of pronation of the foot when the first metatarsal is short than when it is long. We have been unable to find any evidence that the short first metatarsal causes pes planus.*

pronation of the foot, or longitudinal-arch symptoms. (Authors' italics).

Functional capacity in relation to short first metatarsal. "The vast majority of soldiers with measurable shortness of the first metatarsal had no symptoms related to the condition and presented no evidence of disturbance of weight distribution.

Hypermobility of the first metatarsal segment. "... By clinical examination we could not discover any case in which we thought the first metatarsal segment was so much more mobile than the second as to constitute a possible cause of disturbed weight-bearing. The roentgenographic evidence advanced by Morton (widening of the interspace between the first and second cuneiforms) is not pathognomonic. It results merely from the chance that the central beam of the roentgenogram has passed directly through the joint space. In our opinion, hypermobility of the first metatarsal segment does not exist as a separate entity.

Thickening of the shaft of the second metatarsal. "We were unable to find any direct association between thickening of the shaft of the second metatarsal and shortness of the first metatarsal. On the other hand, when the presence of callus indicated that excess weight was borne by the second and third metatarsals, in 44.7 per cent there was thickening of the shaft of the second metatarsal. However, many cases with thickening of the second metatarsal presented no evidence of excess weight borne by it. It may be assumed with reasonable accuracy that, when the second metatarsal bears increased weight for any reason, and has done so since childhood, it will respond with increase in size; but there is no evidence that shortness of the first metatarsal is the cause of such excess weight-bearing."

To be continued.

GIVE AND TAKE

by G. Stanley Mercer

SOME years ago, when this journal changed its policy to one of neutrality and independence, a number of influential members of the profession openly stated that the publication would carry no weight and even predicted its quick demise. I was not, at the time, over-critical of their opinions because, to be frank, I had doubts myself as to the success of any journal operating without the official label of one or other of the chiroprodial organisations. I also had in mind the limited scope in a relatively narrow field. But all who expected the downfall of the journal—and, if I may whisper, those who hoped for it—have assuredly been proved wrong.

I read with pride the messages of goodwill published in our coming-of-age issue last month, from so many outstanding chiroprodial personalities and eminent medical men from both home and abroad. The complimentary expressions contained in many of those messages clearly reflected the influence and power the journal has gained for itself.

It is known that this publication is carefully studied by those officials who are concerned with the anticipated official regulation of the chiroprodial and allied medical auxiliary professions. Possessed with this knowledge, those of us who are entrusted with regular contributions must take care to write soberly, and yet at the same time express ourselves fearlessly according to our convictions. For myself I have, and shall continue, to exercise the right of free speech. If I believe that criticism is warranted I shall express it, but only of principles as distinct from persons. Our Editor hit the nail on the head when he

wrote last month: "...we attack no man, but our concern is with principles, ideals, ideas, hopes, aspirations, facts and their presentation, methods."

It has been said by our critics that we, and myself in particular, seek popularity by playing to the gallery. If the occupants of the gallery-seats are the great multitude of practitioners who practise in the highways and byways, then I willingly plead guilty to the charge. Whom else should I play to? My one and only concern is their best interests. I want to see their conditions of practice and opportunity vastly improved; I want to see a considerable lessening of the distress affecting so many practitioners; I want to see the subject of official salaries vigorously tackled, so that an appointment within the framework of the National Health Service is worthwhile. At the moment the financial end of these appointments is a disgrace.

It is my unfortunate lot to meet, daily, practitioners who are struggling to live decently, fighting odds cast heavily against them. For years now I have dedicated myself to their cause, not very successfully, perhaps, but with sincere intentions and hopes.

Soon, let us hope, the State will close the profession to the charlatans and unskilled, but we must thoroughly understand the State's first concern is the protection of the public as distinct from that of the chiroprodist. It is true that each issue dovetails with the other, but it is the job of the chiroprodial negotiators to see that the profession is not left with the sticky end of the bargain because of unfair regulations.

Under the control and direction of the

Ministry of Health, a working committee is now investigating all aspects of medical auxiliary work. Both chiropodial organisations are represented on this committee and there are indications that the Board of Registration of Medical Auxiliaries will be brought into the picture. In that event a delicate situation is bound to arise, as there are influences within the Ministry's working committee opposed to the policy and activities of the B.R.M.A. To overcome this difficulty a compromise would obviously be necessary; under Ministry pressure this might well happen.

If, as certainly seems likely, the Ministry intends to regulate medical auxiliary practice in its entirety, it will stand no nonsense occasioned by the differences within the sections concerned. As I see it, therefore, the medical auxiliary professions as a whole should agree upon various major points to form a basis of bargaining with the Ministry.

I have but little contact with the

various medical auxiliary professions, other than chiropodial, and so I cannot say whether or not they are wisely led. But I do know that in the chiropodial section there are men and women of exceptional brilliance; my one complaint is that they do not use their gift of brilliance to the fullest advantage and are inclined to pursue out-of-date ideas. If only they can be persuaded to come to conversational grips with those who are trying to reach the same goal but by different methods.

So far as chiropodial affairs are concerned, we all know the fundamental differences between the two controlling organisations. I state emphatically that there is not a single issue of difference which could not be ironed out successfully. One day, out of the blue perhaps, a joint statement of a working agreement will be issued on behalf of the two chiropodial groups. What a day that will be!

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Round and About.

by "Vigilant"



A QUIET CELEBRATION

When the Press has anything to celebrate, "stunts" of all kinds are planned, such as parties and the like, mainly for the purpose of further publicity. This did not happen on the occasion of this journal's coming-of-age last month. The occasion was accepted as just another page in chiropodial history, and all concerned with the publication at once applied themselves to the ordinary routine of the next issue.

It was, however, good to hear so many complimentary remarks about last month's birthday issue. Many chiropodists I have been talking to seemed surprised that so many eminent people sent messages of goodwill. One chiropodial friend, in particular, pointed out that in one or two instances the journal had been very critical of the principles advocated by the writer. I spotted this, too. It illustrates clearly that we can always hold different views, but remain friendly and respectful of each other. We should see much more of that spirit in chiropodial affairs.

COUNCILLOR JAMES MORAN, J.P.

It is with sorrow that I learn of the death of Councillor James Moran, J.P., which took place at Haslingden, Lancs., on July 2. Mr. Moran was a prominent member of the Joint Council of Chiropodists, and was chairman of council from 1946 to 1949—one of the most

trying and difficult periods in Joint Council affairs.

Although quiet-mannered, Mr. Moran was a most forceful personality. He was mayor of Haslingden during 1946 and 1947, and a local magistrate. The profession is very much the poorer by his passing.

GLASGOW CONVENTION

It is now only a few weeks to the Society of Chiropodists' Convention, to be held in Glasgow from September 9 to 11.

It is a characteristic of the Scots to support events of this kind, but the contingent of visitors from the south will, I am afraid, be relatively small. It is not a lack of interest by the southerners, but a matter of expense. At the best of times chiropodists are not exactly a wealthy section of the community, and for the most part they cannot stand the loss of income inevitable when away from their practices.

The convention programme appears to be first rate and the event should be supported by all who can possibly manage to go.

A STRANGE SILENCE

A silence seems to have come over, not just one of the chiropodial organisations, but both. This may be due to the holiday months, when a quiet usually reigns. Or is there something afoot which at the moment is hush-hush? I am just a little curious.

SURGICAL HOSIERY: NEW REGULATIONS

For the first time the Ministry of Health have prescribed a tight specifica-

tion covering the manufacture of surgical hosiery which may be supplied to National Health Service patients. Some go-ahead manufacturers had produced the lastex-yarn type stocking, covered nylon only. By this method a garment not much heavier than ordinary nylons was being marketed. The Ministry's new specification stipulates, however, that the lastex yarn must be cotton-covered. If the manufacturer so chooses he can nylon plate the garment on top of the cotton base, but this of course increases the weight of the garment.

Until Chiropodists become accustomed to the new specification I advise them to obtain from their supplier an assurance that the particular brand favoured comes within the Ministry's prescribed specification — that is, of course, if they are required for N.H.S. patients.

PATIENTS' FEES

The controversial subject of patients'

fees has once again flared up. Why can't there be some reasonable control, ask many chiropodists, hit by trying to compete against cut charges. This cut-price competition is not confined to those practitioners operating outside the jurisdiction of one or other of the chiropodial organisations. It is to be found amongst members themselves. I quite agree that a minimum scale of fees can only be effective if adopted by members of *both* organised chiropodial groups. It is high time something was done about it.

ERRATIC BUSINESS

There is nothing very stable in the reports reaching me from all parts of the country about the state of business. Quite a number of practitioners tell me that they are attending to a record number of patients, whilst others are relatively quiet. The industrial areas seem to be holding their own, particularly those northern towns about to close down for the "wakes" holidays.

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ABSTRACTS

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Journal N.A.Ch. (U.S.A.)

Chiropody is that specialty of medicine and surgery (an ancillary profession) which is concerned with the care of the human feet, in health and in disease. It consists of the prevention, diagnosis, and treatment of foot disorders by electrical, mechanical, physical, medical, and surgical methods, except amputation of the foot or toes, and includes the non-surgical treatment of the muscles and tendons of the leg governing the functions of the foot.

The term "chiropody" was first used in 1768 by an Englishman, D. Low, who wrote a treatise entitled "Chiropodologia." A synonym, *podiatry*, common in a few states, came into use in 1917. The words "chiropody" and "podiatry" were derived from two Greek words—*cheiro*, meaning hand; *pous*, meaning foot. Originally chiropody was the art of treating diseases of the hands and feet, but to-day it is confined to treating the feet.

The chiropodist is one of the guardians of public health, and he shares this responsibility with other members of the healing sciences through clinical experience, education, knowledge, skill, and specialisation. In treating the lower extremities the chiropodist often finds signs of systemic ailments which are reflected in the feet and legs. Some of these are arthritis, arteriosclerosis, anæmia, heart disease, kidney disturbances, and diabetes. The chiropodist is the only practitioner who confines himself exclusively to the care of foot disorders. His practice includes the treatment of skin diseases and infections, shoe therapy, appliance therapy, physical therapy, orthopædic therapy, and surgery.

Prior to 1912 chiropodists secured their training through the preceptorship system. In that year the Illinois College of Chiropody and Foot Surgery and the College of Podiatry of Long Island University were founded to teach the basic principles of foot medicine and surgery. The original courses at these institutions were of approximately six months duration. There are now six recognised colleges in the United States. They have a combined enrollment of nearly 1,000 students, and they graduate annually from 300 to 400.

All six schools are members of the American Association of Chiropody Colleges, which was organised in 1933.

Varicose Ulcer Therapy, by

S. L. Perlman, Pod.D.

This paper offers a brief description of the management of varicose ulcers. In all cases compression treatment is essential. The ulcer is debrided, painted with tincture of merthiolate, sprinkled with terramycin powder with Polymxin B. Sulphate, and a sterile gauze pad is placed over the whole area. A sponge rubber "heart" (a piece at least one inch larger than the ulcer's diameter) is bevelled on the edges and applied over it; then, from behind the first and fifth metatarsal heads, gelatine and zinc oxide impregnated gauze is wrapped (3 inches by 10 yards) up to the head of the fibula. Over this an elastic adhesive bandage is wrapped to include the whole area covered by the gauze bandage (including the heel). Bandages are changed every five days until the edges of the lesion epithelise, after which changes are made every week to ten days. The greatest percentage of area covered by healthy skin will be observed after the application of the fourth or fifth bandage. Another thing that hastens healing is the terramycin powder and the additional pressure of the half-inch sponge pad.

To be able to determine progress without a photographic record, I clear old X-ray film by pouring hot water on it and scraping the emulsion off both sides. This is then cut into pieces 2½ in. x 4 in. (8 pieces from an 8 in. x 10 in. film). The piece of film is put over the debrided ulcer and an arrow is scratched on the film to denote the position of the knee. This is important in subsequent orientation of the films. The outline of the ulcer is then scratched on the film. The name of the patient and the date complete the record. As healing is completed, invaginations of epithelised areas occur and eventually show one or several islands not fully healed. At this time broken lines are scratched on the film to designate the area of the original ulcer. Many patients are delighted to see improvement in the ulcers which have been open and draining for as long as twelve years.

Current Chiropody (U.S.A.)

PROPAGANDA based on fear can grow to devastating proportions. Since this attempt to create the impression that unless we are immediately included in the corporate health plans we shall become extinct as a profession is so disproportionate to the facts, we feel that we must show the other side of the coin.

There is no question but that we are losing a few patients to the health plans, but basically our profession is sound. The major services that we render to the public can be performed only by us, and by us alone.

Corporate health plans have been in existence long enough for our profession to have felt their impact if the public were seeking and obtaining complete foot care through these plans. The fact is that we are still in business and from where we sit we shall remain in business for a long, long time.

Instead of allowing the "prophets of

doom" and their "apostles of extinction" to frighten us into senseless fears for our future, let us redouble our energies toward constructive thinking and activity. When the public has learned that the chiropodist's private office is the place for the best foot care we shall not have to worry about the few who will seek relief elsewhere because it is free, or cheaper.

Chiropody Review (London)

THE BRITISH Medical Association general practice review committee has found that more G.P.s were opposed to health centres than were in favour of them. They suggest that any growth in the direction of such phenomena as health centres should be by a natural development from general practice and general practitioners. In other words, the best way to do these things should evolve in the minds of those who are actually doing them. The fact is that group practice, which is in some ways the inevitable outcome of general practice, is gaining popularity, and is actually being sponsored now by the National Health Service.

For many hundreds of years the institutions in this country have developed (superbly) along their own natural lines, with very frequently splendid results. And that, clearly, is what ought to happen to general medical practice, which has many faults and many virtues (unlike those Socialist doctors who have only virtues, and who want a full-time medical service). The trouble with the suggestion that general practice should develop in its own natural way, a manifestation of the outlook and character of people who live in this country, is that it gives any new Socialist Minister of Health something to do at once. He can compel on the profession of medicine something that its members obviously dislike.

NOTES AND NEWS

Schemes for the Aged

AN OLD AGE PENSIONERS' chiropody service has recently been opened in Portsmouth, under the auspices of the Portsmouth Community Centre and the Joint Council of Chiropodists of Great Britain and Northern Ireland, to enable old people to receive expert treatment at specially reduced fees.

THE SERVICES of a visiting chiropodist are provided for old people who cannot leave their homes in Kensington, London, through the agency of an organisation set up by the Kensington Old People's Welfare Committee to co-ordinate the work of voluntary and official workers.

A PILOT SCHEME to provide chiropody treatment to old people in their own homes has been approved by the Lancashire County Council.

The scheme is to be the responsibility of three divisional health committees in the county. Welfare sub-committees will be appointed to act as a link with voluntary organisations. When a voluntary worker finds a case that her organisation cannot deal with alone the health visitor will be informed and she, in turn, will notify the local medical officer of health.

THE CHIROPODY SERVICE under the supervision of the Old People's Welfare Committee of Bath Council of Social Service has proved a success. During the past year 258 people have received treatment.

Massage Licence Refused

AN APPLICATION to give massage above the knee and ultra-violet ray treatment was refused recently to Mr. F. W. Bar-

rett, chiropodist practising at 186 Sutherland Avenue, Maida Vale, London, at an enquiry held at County Hall, Westminster.

Mr. Barrett said that he attended classes in physical education until he joined the forces, where he took a further course in physical education and remedial exercises and became a teacher in a convalescent home.

After his release from the forces in 1943 he gave massage treatments at Northumberland Avenue Turkish Baths, and after a two-years' course at the Kilburn School of Chiropody he was granted a licence to give treatment below the knee.

It was stated by Dr. A. B. Stewart, deputy medical officer for London, during the enquiry that massage below the knee was part of the work of a chiropodist. A chiropodist's training was focused on that part of the body and his knowledge of the rest of the body was rather sketchy.

The chairman, Mr. A. E. Samuels, said that if an application for a licence similar to that previously held by Mr. Barrett was made it would be granted. Such a licence would permit him to carry on an establishment for giving massage below the knee, chiropody and certain electrical treatments, including faradism, galvanism, radiant heat, high frequency, sinusoidal and infra-red ray.

Walking, not Standing

MR. P. J. READ, F.Ch.S., lecturer in chiropody at Chelsea Polytechnic, said, in a talk on the care of feet at a recent meeting of Tattenham Corner, Surrey, Women's Institute, that feet were made for walking, not to stand upon. He spoke of the wisdom of wearing shoes

to support the instep when household duties were being carried out.

Hospital Chiropody Service

A CHIROPODY service is to be established for in-patients and nursing staff at hospitals in the Blackpool and Fylde (Lancs.) Group.

Foot-care in Mental Hospitals

CHIROPODY CLINICS are included in a list of the improvements made to mental hospitals in the past few years, states Mr. P. M. Lloyd, S.R.N., chief male nurse at Rainhill Hospital, Liverpool, in a recent article in the *Nursing Mirror*.

Doctor Criticises Children's Shoes

THE POOR CONDITION of children's feet at Keynsham, near Bristol, has been condemned by the town's medical officer of health, Dr. R. H. Denham.

He attributed it partially to the poor standard of shoes during the war, but considers that though children's shoes have improved a lot since then, there is still room for improvement.

LETTERS

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not of course, necessarily represent those of the Journal

CORRECTION

SIR,—Thank you for publishing my letter last month in "Queries" so as to help me.

I wish to point out, however, that you said I was 42 years with the ——— Co. when it should have been 4½ years. I should like you to correct this error.—J.R., A.Ch.

EIGHT DAY WEEK

SIR,—Regarding the query from J.R., A.Ch., in last month's issue, your corre-

spondent states (a) that he has ten years of chiropody experience, (b) was trained privately for three years, (c) was engaged by the ——— Co. for a period of 42 years and resigned 9 months ago, and (d) that his age is forty, repeat forty, years.

Just how does he do it, when I with many others would be satisfied with even an occasional eight-day week?

R. F. HARTLEY, M.S.S.Ch.
Plymouth.

We regret the error of having allowed ½ to appear as 2 in the item referred to above. It seems, however, to have aroused interest and, perhaps, some amusement, so has not been entirely without merit.—Ed.

DEMOCRATIC RIGHTS

SIR.—If a few more members of the Society had exercised their democratic rights the profession of chiropody would not be in the mess in which it now finds itself. Every member has plenty of opportunities to express himself at branch meetings and at the A.G.M. The branches can express themselves at area branch meetings direct to councillors about four times a year.

I believe if all members became active the Society would soon be co-operating wholeheartedly with the J.C.C. It may be that the Society training has been accepted—and rightly so—as the criterion for the future but there are in the Society a lot of chiropodists who may find it as difficult as J.C.C. members to get on the M.O.H. lists. It must be remembered that the Minister only requires a small number of chiropodists and there are plenty of two-year-olds in the stables willing to enter for the "Macleod Stakes."

JOHN R. S. JOLSON, M.Ch.S.
Oxford.

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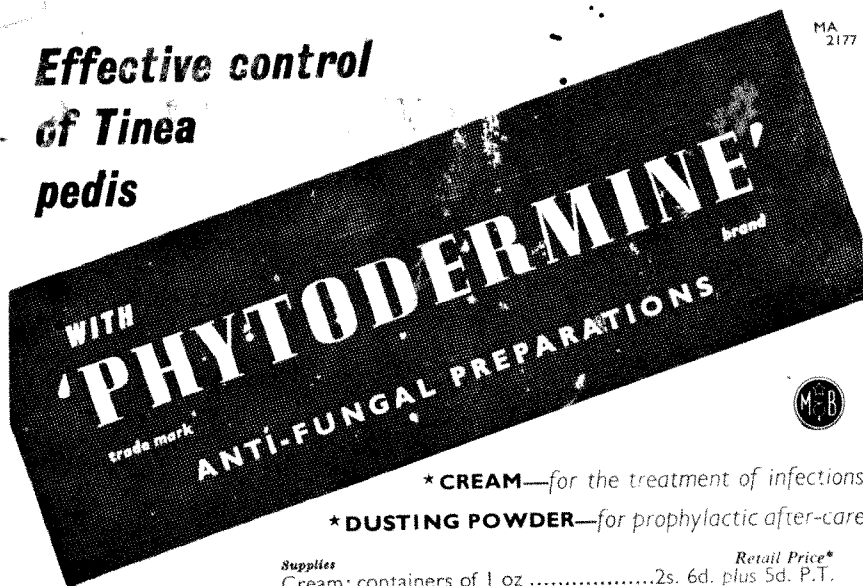
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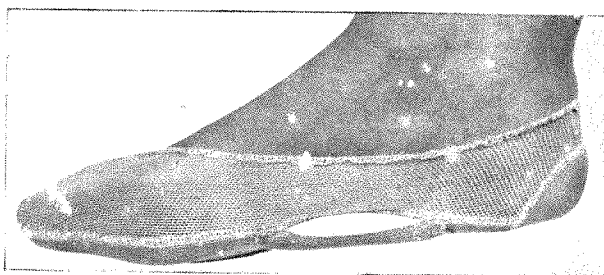
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VIEW POINT It is the privilege of Editors of journals to receive expressions of opinion from a variety of sources, and it is understandable that these opinions should be coloured frequently by personal interest rather than by the long-term interest of the profession as a whole; even when the latter interest is predominant and genuine the outlook indicated varies considerably.

It is obvious that the outlook of the person who takes a short correspondence course before launching out as a "fully qualified" chiropodist differs widely and essentially from that of a graduate from a two or three-years full-time course of thorough training. The effort which these two types have had to put forth, the financial investment which they have had to make, vary so widely and fundamentally that they find themselves on completely different planes of existence. The untrained person is often inclined to choose to ignore the difference between his own and the professional equipment developed by a full training course and often assumes terms of equality which the full-time graduate can scarcely be expected to concede; the frequently uses the freedom of the profession to augment his income from other source — often a trade-unio-

tected occupation—whilst the other starts with the idea that chiropody is *his* profession and must be his life's work by which a dignified livelihood must be derived for himself and family as the years go by.

In this matter the graduate from the full-time training school, with his rent, rates, expenses of materials and equipment, plus general maintenance and overhead expenses, his obligation to keep accounts and pay income tax on results, is at a disadvantage; the "sniper," on the other hand, operates from the cover of another occupation, of which there is an ever-growing list to which I have recently had to add that of a hospital nurse and a schoolmaster. Of course, chiropody is not the only profession invaded, for I knew a bank manager who used to "do a bit of massage."

I am aware that qualified and experienced chiropodists are to be found outside the ranks of the two main organised

We wish that the profession

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juring, their railway work, their ledgers, and what not.

Certain it is that no person can offer his services to the public as doctor or dental surgeon without having first acquired the legal qualification, and that is the desirable position which we envisage for chiropody.

What now? Will such a position result from the discussions now being carried on by the Minister of Health? We cannot know, it depends primo on whether the M.O.H. is prepared to enter into our affairs in such a way as to see and appreciate our vital needs and professional aspirations for which men of vision and integrity have struggled for the last two decades. Can he be expected to concern himself beyond his desire to regulate N.H.S. employment? Can he be expected to do for chiropody what chiropody has so far been unsuccessful in doing for itself? Certainly there is one result which he instantly achieved, and that was to make the Society and the Joint Council sit down and talk business. Our readers will recollect that it was in May last year, when voluntary action was still possible, that we observed: "It must be obvious to any very casual observer that the J.C.C. and the Society only seem to get nearer together in so far as they are pushed by circumstances and Ministerial action." Both these external forces have at last operated to oblige the Society to do what the J.C.C. invited them to do long, long ago.

We must, however, not delude ourselves into thinking this is an affair of chiropody alone. Oh, no!; this is a complicated affair of the group of sundry bodies of medical auxiliaries. There are dieticians, orthoptists, speech therapists, radiographers, physiotherapists and what not; all excellent people, but without the

peculiar problems which face chiropody, and numerically vastly inferior. We feel that chiropody should be dealt with as a profession apart from all these other auxiliaries by separate legislation. Will it? That depends very largely on the efforts of your negotiators. The lack of unity in the profession to which we have for so long been drawing attention and which has resulted in the lack of an agreed common policy has left us in a weakened position from which to negotiate. But it would be interesting to know what the negotiators are striving for; it is a matter which vitally concerns every single chiropodist and not merely N.H.S. employees, present or future.

SUGGESTION We suggest that it would constitute a valuable gesture of goodwill at the present juncture if an invitation were extended to members of the J.C.C. to attend educational events at the Society of Chiropodists' convention in Glasgow from September 9 to 11, and that passes be issued on individual application before the date.

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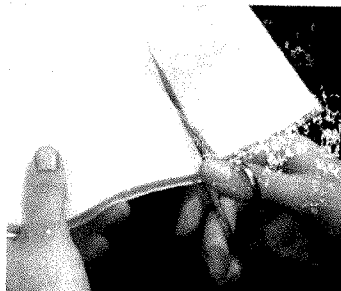
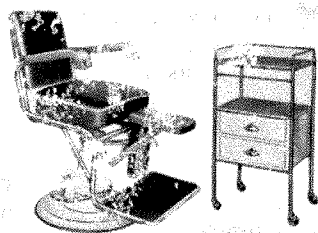
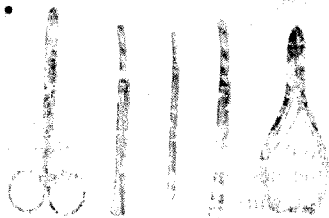
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CORNIFICATION AND PARAKERATOSIS

By B. Dalton, M.Ch.S.

CONTROVERSIES abound in chiro-podial literature and theory to-day. Some enigmas have been successfully answered, but many still await revelation. One intriguing problem is the fact that even though there is a distinct increase in cellular proliferation in cases of corns and callous, there is also a contemporaneous retardation in the rate of desquamation. Here is a seeming paradox. Why should continued stimulation of the skin produce excess multiplication of cell and reduced surface loss at one and the same time? How is such a state of affairs made possible? Perhaps, on closer examination, the difficulty may be resolved without distortion of fact.

Roxburgh¹ states that in all cases of skin inflammation there is a degree of parakeratosis. The above statement may be used as a suitable premise from which to deduce the answer to the question of why there is a retardation of desquamation in cases of corns and callous, when these lesions are the results of over-stimulation. This is still the object of much speculation.

First let us establish that corns and callous result from a degree of inflammation. There is little doubt that this is the tissue's response to stimulation; whether the irritation results from constitutional factors or external agents is quite another matter. Admittedly there are cases where it is especially difficult to demonstrate that inflammation exists to the naked eye, nevertheless there is extensive tissue damage on a microscopic scale; but, on the other hand, there are cases where there is visible inflammation.

An initial reaction to the stimulus necessary to produce cornification is a degree of parakeratosis. Hitherto this term

has only been applied to the nucleus of a corn, in which there is ample evidence of tissue change. The term means a state of imperfect keratinisation. One of the main features of parakeratosis is spongiosis, which is an inter- and intra-cellular oedema, resulting from the "triple response" of Lewis. He also demonstrated that this oedema is caused by the release of "H-substances" from the damaged cells. These chemicals greatly increase the capillary permeability. It appears that histamine is normally present in the body cells.

The spongiosis directly interferes with normal keratinisation. Inter-cellular oedema causes a microscopic separation of the epidermal cells; this parting must mean a variation in the cell's normal environment with consequent effect on its future development. The resulting horn cells are moist and sticky and tend to agglutinate, producing a hard, shiny, amorphous mass of highly keratinised cells. This changed surface immediately alters the rate of loss. The coefficient of friction is very much lowered. Thus, clearly, fewer cells can be rubbed off. This retardation forms a very efficient protection for the delicate structures beneath. It would be only natural to expect an increased surface wear with increased stimulation, but what actually happens, i.e., parakeratosis, amply demonstrates the capacity of Nature to protect her tissues from the increased wear by the simple mechanical means of lowering the surface coefficient of friction.

Since the release of H-substances plays a very prominent part in inflammation, it would be as well to examine this more closely. Perhaps it is the high degree

of energy concentration and therefore high temperatures which cause the formation of these all-important chemicals. If this question of energy concentration is pursued it will be found that on a microscopic scale it is, indeed, very great. Now the stimulus in the case of corns and callous is mechanical and frictional in nature. A study of friction² reveals that the contacting areas are subjected to great pressures and high temperatures; consequently the surface deformation is very drastic. It has been determined by supersensitive electrical measurement that the real areas in contact represent less than one ten-thousandth part of the apparent areas. Now, if only a few pounds weight press these surfaces together, the pressure at the actual points of contact is of the order of hundreds of pounds per square inch, and because of such great pressures there occur high temperatures.

The foregoing physics merely illustrates that in dealing with friction there is a great energy concentration which hitherto has been ignored. The combination of temperature and pressure in friction may produce a very localised but extensive cellular metamorphosis, and perhaps excess keratin by coagulation. Heat is one of the most important means in producing certain proteins.

When Lewis speaks of the release of H-substances, it really implies them to be present as such in the ordinary cell. But

is this so? Could they be liberated in sufficient quantity to effect the capillary permeability? It could be that they pre-exist in the cell not as H-substances, but as certain chemical derivatives which combine to produce them. Do they exist as such or are they produced, not as a result of oxidation alone, but rather in the nature of chemical change instigated by the high temperatures and pressures of friction?

Conclusions

1—The retardation in the rate of desquamation is a direct result of the lowering of the surface coefficient of friction caused by the agglutination of horn cells in parakeratosis.

2—There would appear to be a relation between the production of keratin and temperature. Perhaps the protein is coagulated by heat, one of the most important means of producing insoluble proteins. Keratin is a scleroprotein and is insoluble in water, alcohol, and ether.

3—Physiology informs us that histamine is a product of tissue breakdown. It would appear that the H-substances are produced by the tissue breakdown in inflammation. This is not just a simple liberation, but a definite chemical reaction.

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FUNGUS CONDITION DIAGNOSIS*

By David Meakes, D.S.C.

CHOOOSE any book from the choicest selection of chiropody texts. Read every page slowly and every paragraph carefully. How many times will you find even an oblique reference to the microscopic procedure of diagnosis of

fungus conditions of the feet? I venture to say but once or twice! Considering the apparent prevalence of tinea pedis (athletes foot, epidermophytosis, trichophytosis), the lack of professional and research material on this troublesome condition is lamentable to say the least.

* Reprinted from *Chiropody Record*, U.S.A.

Tinea pedis, or "athletes foot" as it is known to the laity, is constantly being brought to the attention of the general public by advertisements for scores of patent remedies. None of these can be considered particularly efficient; usually the chiropodists' or physicians' prescription cannot be relied on to any greater extent. The very multiplicity of "cures" is evidence of their own inadequacy. One efficient agent and the many proprietary preparations would fade from the market.

Tinea pedis has always appeared to be very resistant to treatment and an apparent cure for one patient will fail for many others. I feel that one reason for this is that tinea pedis has become the scapegoat of a host of dermatological conditions. It has always been easy to look at a skin condition of the foot, say it is athletes foot and start some treatment which probably goes on for months and gets mediocre or no results. Many first-class dermatologists have stated that even the most experienced of them find that their tentative diagnosis is very frequently proved wrong by their subsequent microscopic examination. Consequently, I feel that a great many cases of tinea pedis are simply mis-diagnosed becoming confused with simple hyperhidrosis, eczema, the many varieties of contact dermatitis, etc.. Because of its many clinical forms it can easily be mistaken for one of these other clinically similar conditions.

It is a crime against the high professional standards of the chiropody profession not to take advantage of the brief, simple procedure of taking a microscopic slide. When one considers that a time investment of from four to fifteen minutes usually leads to a reasonably conclusive decision as to the presence or absence of tinea pedis, it becomes immediately apparent that many doctor and patient hours are squandered every day on useless therapy, which this brief time outlay would save.

One question which immediately comes

to mind is that regarding the degree of accuracy of microscopic examinations. In 1948 and 1949 the writer was privileged to assist in a mycology laboratory project of clinic patients at the Chicago College of Chiropody and Pedic Surgery. Microscopic slides of 300 tissue specimens were examined of which 169 were also cultured. Culturing consists of the insertion of the suspected material by sterile technique into a sterile test tube containing a suitable media for the fungi to grow on. These are then kept at the optimum temperature for growth of the fungi. Of these 169 cultured specimens there were only 6 whose corresponding slide was negative. As cultures are found to be positive in approximately only 35 per cent of positive cases of tinea pedis (those cases already proved by microscope), it was felt that a positive microscopic slide with a corresponding negative culture was not sufficiently significant to be considered. Multiplying the 6 negative slides by three, to represent the approximate, probable, proportional error which would be found if 100 per cent of the positive cases of tinea pedis grew in culture, we arrive at the figure of 18 which is the probable error in the 169 cases. This is 10.6 per cent of the 169 cases which indicates an accuracy of about 89.4 per cent in microscopic examination of both positive and negative tissue specimens.

Another factor in looking at these figures only from the negative slide and positive culture standpoint is that slides were not recorded as positive unless the fungus was actually seen, thus leaving little room for doubt regarding the positive slides. "Seeing is believing" and a faulty visual interpretation of positive material by a moderately experienced examiner is extremely unlikely. Therefore a slide, declared positive on microscopic examination, indicates with virtually 100 per cent accuracy that the patient has tinea pedis. However, a negative slide does not indicate

with similar accuracy that the patient has not got tinea pedis. The particular lesion from which the examined tissue taken may not have any fungus involvement (as probably happened with the 6 cases mentioned above).

The section of tissue may be too thick to allow favourable examination. The specimen may have been taken from a portion of the lesion least likely to present the fungus. So a negative report must be accepted with considerably greater reserve than a positive report. If still suspicious that the condition is tinea pedis, the practitioner should repeat the slide.

When taking tissue from the patients' foot for examination there are a few things to keep in mind. In the crumous or scaly type and in the hyperkeratotic type it is best to take the tissue from the periphery of the lesion. For instance, a flap of peeling skin is clipped off and discarded and the tissue to be examined is taken from the margin of the apparently normal skin which is where the fungus will be found to be most active. This applies to the chronic intertriginous type also. In the acute vesicular type the vesicle is clipped off and the inside of the vesicle is placed upwards on the slide as this is the area of the greatest activity of the fungus. Care must be taken that a representative selection of tissue be chosen. If lesions are widespread secure some tissue from the heel, ball, dorsum, interdigital folds, etc. As one area may exhibit the fungus more readily than another or as the lesions in one area may be negative altogether this representative sampling of tissue may eliminate error. In the pyodermic or secondarily infected lesions, tissue may be taken from the periphery, but it may be found advisable to eliminate the infection first.

Place the suspected material on a slide, add a drop or two of 15 to 30 per cent potassium or sodium hydroxide, apply cover slip, apply gently heat for a moment

if desired, and allow it to soak for 4 to 5 minutes, or if circumstances allow, 10 to 30 minutes, during which time you may be continuing with the care of your patient. Then examine the material under the low power field of your microscope. One hundred power will be found suitable magnification. If the tissue is thick, dense or corneous in nature it may be necessary to allow an extra few minutes of soaking, so that the hydroxide may more fully separate the tissue cells, thus permitting the fungus to be more clearly visualised.

I shall not attempt to portray in any great detail what is to be seen on a positive slide. One good picture or a positive slide would greatly exceed in value many pages of description. However, a brief outline is necessary to complete the picture.

Two terms which must be mastered at this point are hypha (plural is hyphae) and mycelium (plural is mycelia). The multicellular fungi are largely made up of cells attached end to end to form long filaments or hyphae. These branch, entwine and anastomose making up a mycelium. One may see only an occasional hypha or may see a network or mycelium or several mycelium, all of these cases being positive. The hyphae must be differentiated from threads, long crystals of hydroxide and other artifacts which may confuse the examiner. This is possible under 100 magnifications but if a more powerful magnification is available to the beginner it would be preferable to use it. 300 to 700 magnifications will very clearly show the cellular structure of the hyphae with septae or transverse walls at intervals. However, this bulbous appearance of the hyphae can be very clearly distinguished with a simple microscope of 100 power. Elliptical spores may be seen usually lying independent of the hyphae. The branching of the hyphae may also be clearly seen.

The examiner must not expect to be

able to differentiate the various groups, species, etc., by microscopic examination of fungi in skin tissue. This classification can only be done by macroscopic and microscopic culture examination. It can only be said that the microscopic tissue examination demonstrates the presence of a fungus of unknown species which is, at the present stage of research, all that is required to insure more appropriate therapy.

Examination of nails to determine if onychomycosis is present is done in a similar manner to that described above. Shavings of the inner surface of the apparently infected nail will be found to be most satisfactory for investigation. The cheesy material beneath the nail is usually found to be completely amorphous with no retention of cell or hyphae structure. A clipping of the nail is usually too thick to be viewed satisfactorily. The material may require longer soaking in the hydroxide, sometimes hours being needed, followed by gentle finger pressure on the cover slip to spread and so diminish the depth of the material to be examined.

As previously pointed out, a simple microscope of only 100 magnifications

is all that is necessary to locate fungi in a positive tissue specimen. The expense of the microscope, slides, cover slips, and hydroxide solution would be very small compared with the value received from their use.

Even the most superficial consideration of the foregoing discussion will be sufficient to emphasize the brevity, simplicity, and accuracy of microscopic tissue examination and consequently the desirability, in fact the necessity, of each and every chiropodist equipping himself with the necessary supplies and the knowledge to enable him to carry out these examinations. The financial investment will be reaped a hundred-fold in time saved, elimination of indecision, success of therapy, and acquisition of patient and physician respect.

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Conant, Martin, Smith, Baker and Callaway,—*Manual of Clinical Mycology*.
Andrews,—*Diseases of the Skin*.
Pardo-Castello,—*Diseases of the Nails*.
Lewin,—*The Foot and Ankle*.

THE WEAKFOOT CONCEPT—Part V*

by L. F. Schreiber, F.A.A.C. (Hon.) F.A.C.F.O. and
H. W. Weinerman, D.S.C.

THE METATARSAL FORMULA Ample evidence is adduced by F. Wood Jones²⁷ to indicate that metatarsal formulas (the order of projection of the heads) are nothing new, dating back as far as 1855 (Henle) and continuing in a steady stream as recently as 1940 (Frazer). By far the great majority of authorities on anatomy agree that the skeleton of the foot depicts

the order in the formula as: (a) $2 > 3 > 1 > 4 > 5$. Next in frequency, another but smaller group of authorities arrived at the formula as (b) $2 > 1 > 3 > 4 < 5$. It is notable to observe that in group (a) the first metatarsal is third from the longest. Commenting on the subject, Jones states:

"It is the head of the second metatarsal that is typically advanced beyond that

*Reprinted from Journal N.A.Ch., U.S.A.

of any of the others. Although the head of the second is, except in rare and abnormal cases, the most projected in the foot, there is the possibility of some slight variation around this mean... In the absence of any statistical inquiry into the subject, it is no easy matter to be dogmatic on the point. *Such an inquiry would have to be conducted by forceps and scalpel*

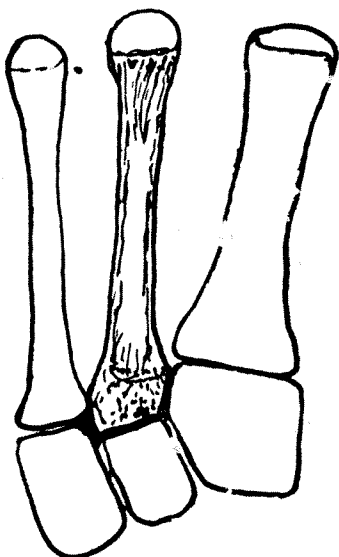


Fig. 2. — Slotted articulation of metatarsal II with cuneiform II and adjacent cuneiforms. This metatarsal is the longest in the series, both at its head and base (dorsal view, left foot).

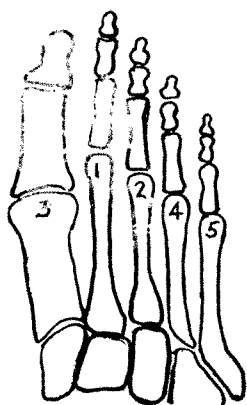
rather than by radiograph or by the examination of articulated specimens, for into both of these methods fallacies may intrude. . . . The head of the third metatarsal may occasionally outstrip the second; but the fact remains that it is normal in man for the head of the second to be the most advanced member of the series. . . Far from being anything like an abnormality of any sort, it is the accepted normal of all anatomists. . . The head of the second metatarsal sad incef ofva

that of the first at all stages of development —the condition is no adult acquirement." (Authors' italics). (See Fig. 2).

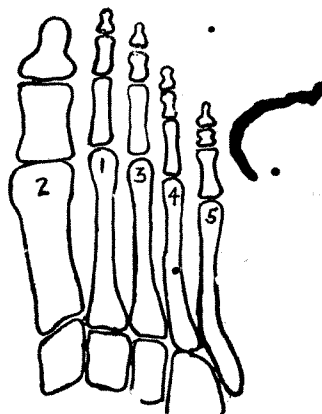
On the basis of this statement by Jones, Morton (1935) stands alone among all authorities on anatomy, even though he regards a short first metatarsal as one which "can hardly be called a definite abnormality." As brought out by Jones, the second metatarsal articulates "with the tarsus farther back than those of its immediate fellows. Moreover, this articulation is in every way peculiar, since the base of the bone is slotted in between the margins of the two adjacent cuneiforms and sides of the base of its fellows." This articular peculiarity is further emphasised by noting the relative distal shortness of the second cuneiform in its wedged position between the first and third (See Fig. 3).

The position of the anatomist in working with "forceps and scalpel rather than by radiograph," as recommended by Jones, suggests greater scientific accuracy in the results. This position is partly confirmed in the admirable work of Venning and Hardy²⁸ who make it clear that precise radiographic technique can do better than standardise unavoidable distortion when, they state: "A shadow is, of course, inevitably distorted to some extent unless it is cast by a plane upon a screen in contact with the plane. However, the aim in producing standard radiographs is not to avoid distortion, but to ensure a constant amount of distortion on each occasion." (Authors' italics).

RADIOGRAPHIC TECHNIQUE This now brings us to the point where it is essential to review criticisms that are likely to arise from a consideration of the various radiographic techniques employed in studies of the skeletal structures of the foot by Morton (1935), Harris and Beath (1949), and Venning and Hardy (1951). With all due consideration and respect



A



B

Fig. 3. — Illustration A depicts metatarsal formula accepted by great majority of authorities on anatomy: $3 > 1 > 2 > 4 > 5$. The numbered heads indicate the order in which the metatarsals project in length. Illustration B depicts the formula accepted by a smaller group of authorities: $2 > 1 > 3 > 4 > 5$.

to these and other workers in the field, allowance for distortion, even if standardised as pointed out by Venning and Hardy, leaves out of consideration significant variations among numbers of individuals grouped together whose foot-build cannot be standardised for radiographic purposes. This factor applies to those exhibiting *pes planus* or *cavus*, the dual bone morphology, the age over a period of years, the various lesions and deformities which bring a corresponding articular and other misplacements under Wolff's law, and the general changes in contours that may be apparent even externally.

On this basis, we hold that any individual can exhibit, radiographically, what may be termed a standard applying only to himself if the range of architectural variation is outside the average of his group classification. On the other hand,

with standardisation of distortion for any group coming within average morphological build, this factor is reduced to a much smaller margin of error in the interpretation. As an example of the discrepancy that might creep into radiologic studies, a long foot with a higher-than-average longitudinal dome will show greater distortion than a short foot with a lower-than-average longitudinal dome, even in the same sex. In these cases it is obvious that the greater the distance of part of the foot from the screen, the greater the distortion, since the general build of the foot presents the form of an arc in any position, unless it is radiographed contrary to the precise technique recommended by Venning and Hardy, in which case the distortion will be still greater.

The crux of the problem thus brings us back to anatomy, rather than radiology, as presented by Jones (1944) when he

states flatly that error will intrude itself in such studies, the best solution being the forgeps and scalpel, where distortion is impossible and interpretation is precise.

There is hardly a need, as we view the problem, to assume that Morton is in complete error, or that Harris and Beath are only partly correct, while Venning and Hardy hold the complete solution in radiographic technique of the foot. Since no fool-proof method has as yet been devised, further judgment must be withheld pending future investigations, perhaps in the field of anatomy.

THE SHORT FIRST METATARSAL

The majority of anatomists (cf. F. Wood Jones) agree on the metatarsal formula $2 > 3 > 1 > 4 > 5$, indicating that a short first is normal. It likewise indicates that since the position of the first in the formula rarely occurs after the third or middle place, its shortness may be considered merely as a natural architectural feature of no pathognomonic significance at any time of life. Since nature provided this architectural arrangement she is quite capable also of providing the necessary biomechanical and functional capacity for the short first segment to perform its work efficiently. The fact that at the approach of middle life many of the nummular disorders of the feet begin to antefest is no indication that architectural build is the direct eticologic factor responsible for such disabilities.

It is a fact also that many other parts of the human organism begin to show signs and evidences of functional incapacity and disease bordering on degenerative processes. With the exception of the human foot, soft tissues and osseous structures of the rest of the human frame (architecturally speaking) are not customarily taken into account when various parts become pathologic, unless, as applies equally to the foot, tissue changes indicate the presence of a disease process. But

such systemic processes, either in the foot or elsewhere in the body, are not to be confounded with this discussion in which purely biomechanical disorders are considered apart.

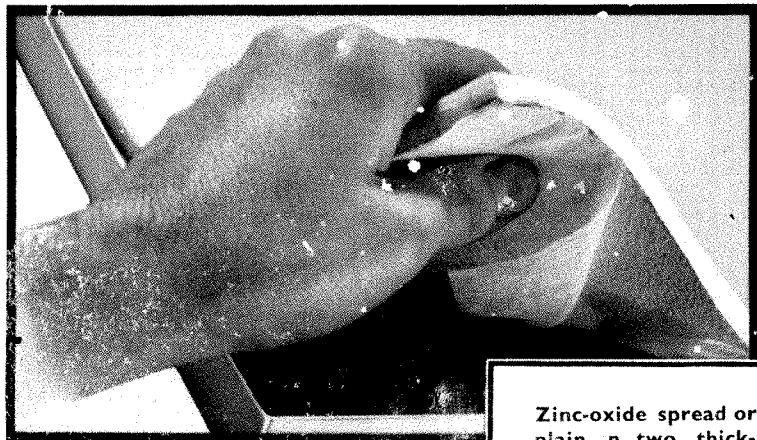
We must learn to accept the lesson from the world's leading anatomists that a short first is as natural as a thumb, and that one can live with it in peace if he does not entertain scientific speculations and evolve fanciful theories concerning its relative shortness as nature designed it. Nothing can be done about it, anyway, even with a platform placed under its head to give it a lift which it almost always promptly resents. The system of biomechanics of the body is governed by the laws of physiology, partly recognised under Wolff's law and Davis's law. These laws do not take into account the possibility that some men will attempt to assess the handiwork of nature by some dubious process of reasoning, contrary to what is simple and adequate for all practical purposes of observation and study.

In any consideration of metatarsal formulas, it is perhaps more practical to take into account the general relationship of the projection of all five metatarsal heads as a unit, rather than to consider the limited relationship that exists between the first and second only. These two may present a longer or shorter relationship to each other which may prove misleading if the remaining three

If the second appears excessively in relation to the first, thereby giving the impression of a short first, what is the relationship of the first to the third, fourth and fifth? It is quite possible also that an excessively long second aids in counterbalancing a so-called short first, since the second belongs on the medial side of the foot. In any event, why not resort to the dissection and study of foot cadavers and anatomic specimens for additional observations, rather than to rely on the present method of interpretation of radio-

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graphic distortions and other anatomic inconsistencies and anomalies?

Summary

The weakfoot concept has prevailed since the late nineteenth century and was adopted in chiropody four decades ago. It is shown that function plays little part in this concept, which is based solely on the postular position of the subtalar articulation, resulting in natural pronation.

2. The foot is a primordial structure of incalculable age, while its general morphology has remained basically unchanged, as shown by anthropological excavations. The pronated foot, the oddly shaped foot, and other variations in pattern, are as normal in function as those whose structure is not "impaired" morphologically.

3. Histological and morphological changes take place in accordance with the law of adaptation of structure to function. Such changes provide the greatest economy to suit the individual requirements in locomotion, except in the presence of trauma or bone disease. The law of adaptation follows in a series of sequential steps: (a) change in position, (b) change in function, (c) rebuilding by germinal cells, (d) morphological changes (anatomic results).

4. Abstracts from Davis's monograph are presented in relation to tissue-structure changes responsible for distortions and deformities of the body. Among those we may include are distortions of the forefoot commonly seen in chiropody practice, but not applicable to so-called "weak foot" the latter being a natural "distortion" common alike to savage and civilised man.

5. An illustration of the statement, "indoctrinated with habituated forms of thinking in the realm of the scientific," is given when a troupe of Igorrotes (a savage tribe) was presented at a clinic by

an orthopaedist to his medical students. All were chagrined to find the troupe *flat-footed* in barefoot stance, with *pronation*, yet presenting superb functional capabilities, contrary to the ideas indoctrinated at medical school on what constitutes the natural foot.

6. Concerning rigidity or flexibility of the arch, tabulation of 11 authorities shows divided opinion, four considering it rigid, six flexible, and one self-contradictory. Voicing a personal opinion, we stand on middle ground on the basis of anatomic observations: (a) lateral and medial torsion movements of the forefoot, (b) adduction and abduction of the forefoot (Chopart's articulation), (c) relative rigidity of the rearfoot (talus and calcaneum), thereby presenting a semi-flexible skeletal structure.

7. Sturdy construction of the rearfoot gives it greater integrity and defence against shock and disalignment than is the case of the forefoot, since the latter performs the delicate functions of balance through intricate semi-flexible movements. The skeletal quaternary (talus, calcaneum, tibia, fibula) provides a solid column of vertical support and tremendous stability to meet adequately all normal strains and stresses.

8. As demonstrated by engineers, the shock-absorbing property of the foot is extremely high, since extensibility of the plantar aponeurosis and other fibrous structures is limited to 1.4 per cent. Pronation *per se* is thereby limited by these structures as a natural phenomenon in the cycle of static and dynamic forces in the act of locomotion.

9. Abstracts from the research team of Schwartz and Heath are presented to indicate that the inherent variables of structures of the body or the foot allow for variations within the classification of normal. These workers state that "a maximum understanding of the requirements of the human foot for its most

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efficient functioning" must be reached by "recorded evidence capable of quantitative measurement and interpretation" if all forms of therapy are to rise above the empirical.

10. Copious abstracts are presented from Harris and Beath on clinical findings and statistics tabulated in the Canadian Army Foot Survey with concrete evidence to scatter the Morton syndrome. Their evidence indicates that they determined the functional capacity of the feet of Canadian soldiers "by observation of the type and degree of disablement which developed during military training." Reontgenologic studies of 3,619 men proved: (a) in 1,282 the first metatarsals were shorter than the second (approximately 35 per cent), (b) in 2,337 the first and second were either of equal length or the first was longer (approximately 65 per cent), (c) flatfoot and pronation are not caused by the short first, (d) no evidence by the short first of related symptoms or faulty weight distribution, (e) hypermobility of the first segment is apparently non-existent, (f) no association between thickening of the second from excess weightbearing and the short first.

11. As shown by Jones, all metatarsal formulas presented by anatomists from 1855 to 1940, with the exception of Morton (1935), depict the second metatarsal head in advance of its fellows. This fact "is the accepted normal of all anatomists," is not considered "an abnormality of any sort," and remains in advance of the first throughout life. Jones adds that "forceps and scalpel" would be required for accuracy rather than the radiograph and its unavoidable distortions, especially in view of the findings of Venning and Hardy (1951) regarding the latter.

12. With recent attempts to standardize radiographic distortion, additional factors intrude themselves to present new complications and thus defeat its own purpose. It is pointed out that the ex-

tremes of planus or cavus, because of the widely different arcs exhibited, are likely to increase, rather than diminish, the margin of error in the interpretation of standard distortions. Morphological changes, including skeletal and articular distortions, resulting in exaggerated arcs and angles, are among the factors to consider in such radiologic studies.

COMMENT In a paper of this nature, emphasis is necessarily directed to the negation of a concept having popular approval. But on the side of the positive there is ample material to build anew on the site occupied by the former structure. Such material is available and is being utilised in the profession. Those who have availed themselves of it prior to, and since, its introduction in these pages in 1948,²⁹ have been startled with incomparable results not realised in the past when the weakfoot concept represented the focal point of the therapeutic attack.

In connection with the material referred to, specific terminology may be suggested for adoption by employing the phrase *torsion principle* to denote medial or lateral imbalance of the forefoot. A companion phrase, *torsion stabiliser*, may be suggested to denote the pad or appliance devised to restore balance, as shown by a reading taken with the *supronimeter*. Combining the three aspects of this material into an all-inclusive system, we take the liberty, not usually the privilege of originators, of respectfully suggesting that it be named S-W method.

In a previous paper, a proposal was made to adopt the newly-coined term *podoinstability*³⁰ to replace such outmoded terms as *weakfoot* and *flatfoot*. This word represents the generic rather than the specific, in conformity with the law of locomotor stability³¹ introduced to the profession as an original contribution.

(To be concluded)

SECRECY IS UNNECESSARY

by G. Stanley Mercer

ONCE again I have been tempted to quote from a contemporary journal. I do not particularly like this practice as it so easily gives rise to unpleasant controversy. Upon this occasion, however, I feel I am on safe and firm ground, by quoting from the editorial of the *Chiropody Review* July issue. In a reference to the working party committee sponsored by the Ministry of Health, the Editor writes:—

On that working party there sit representatives of both groups of the profession. It seems worth mentioning, lest there be any attempt to propagate a contrary view, that an extremely harmonious relationship exists between the representatives of the Joint Council and of the Society who met on the committee.

That this should be so gives us the greatest possible pleasure, not merely because it facilitates the smooth progress of the discussions, but because it shines a light on the future of chiropody which may become intensified to reach a dazzling brilliance.

Seldom have I read such refreshing words in chiropolitics. In one thrust they seem to pierce the heavy clouds which have for so many years blotted out the sunshine. Does it matter very much that it required the machinery of officialdom to force the two groups to the same conference table? Let us content ourselves in the happy realisation that those chiropodial leaders who only yesterday were strangers to each other have to-day, at least, extended the hand of friendship.

We must not, of course, delude ourselves into the belief that overnight the chiropodial waters have become calm. Far from it. Tremendous differences remain to be settled, but by compromise

and determination every problem, small or large, can and must be satisfactorily settled.

We all know that events in the chiropodial field are moving to a climax. We know, too, that the profession's future destiny is soon to be determined by the tight laws of protective legislation. It will require the best brains within the profession to see that its just interests are preserved and safeguarded.

Those of us responsible for chiropolitical expression in the various journals must exercise a discreet restraint and write not one word likely to jeopardise the delicate negotiations which have already opened. I do not suggest that we should put up the shutters and meekly await events. Our function must surely be to advise in a spirit of helpfulness those who are charged with the delicate task of negotiation.

But first of all let us all be open and frank with one another. In the kindest spirit I suggest that the Society particularly should relax its unnecessary attitude of extreme secrecy. I have no doubt that it has been well meant in what it believes to be the interests of diplomacy. Anything which gives rise to suspicion and doubt can hardly be termed diplomatic.

The future status and conditions of practice are the concern of every practising chiropodist. It is his right to be kept fully informed as to the progress of events, not left in almost total ignorance of what is taking place.

I am anxious not to be misunderstood. I quite realise that when delicate negotiations are proceeding the details can seldom be revealed until the subject of them is concluded. But to make a per-

petual practice of pointless secrecy is a very different matter.

The same applies to the chiropodial Press, and this journal in particular. It is an independent publication, circulating widely amongst all groups of practitioners. It is our function to keep our readers authoritatively informed, but had we been compelled to rely upon information imparted to us by the responsible chiropodial groups, we should have had but little to impart.

Happily, however, the organisation of this journal is complete and if information is lacking from one quarter it is usually obtained from another. It is necessary to explain all this to justify my proposal that the chiropodial organisations establish a system of Press conferences.

The present chiropodial situation is

critical and delicate. For that reason alone the release of news and information should be regulated by a mutual understanding between the responsible chiropodial groups and the Press. It is not my wish to publish information of an important nature if for some reason or other, unknown to me, it is genuinely undesirable or premature. A properly conducted system of Press conferences would minimise this danger. I should add, however, that I would decline to take any part in the unnecessary secrecy complained of earlier.

I have enquired of our Editor his reaction to the idea of Press conferences, for in so far as this journal is concerned it is, after all, for him to determine its attitude to the proposal. I am glad to say it receives his approval.



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Round and About.



by "Vigilant"

CONVENTION

THE SOCIETY of Chiropodists are making final preparations for the Annual Convention, this year to be held at Glasgow from September 9 to 11.

If the weather man relents and promises us a spell of good weather during the convention, it should swell the attendance. Many chiropodists I know have purposely delayed their holidays because of the miserable weather we have been having. They might now be tempted to take a late holiday, and what could be nicer than a holiday in Scotland, combined with a visit to the convention?

I am told that the various supply houses exhibiting at the convention are planning attractive stands.

APPOINTMENT FOR THE ESSEX COAST

ALTHOUGH I have a long list of chiropodists seeking appointments, not one happens to be interested in going to the Essex coast. I invite anyone interested, lady or gentleman, members of either the Society or Joint Council, to contact me at once. The appointment is urgent.

REGULATING FEES

EVERYONE in the profession admits to being extremely worried about the increasing evil of fee cutting.

In one northern industrial area it has become a serious problem. One chiropodist I know has had to make two recent cuts to compete with his fellows.

Why is everyone so shy to tackle this problem vigorously?

VERRUCA PEDIS

IS THE painful condition of Verruca Pedis on the decline? One practitioner known to me who deals extensively with children tells me that he is dealing with twice as many youngers as compared with two years ago, but is treating less than half for the condition.

If there is a marked decrease in the number of sufferers it is no doubt due to precautions being taken as the result of foot care education in the schools.

OLD-AGE PENSIONERS

IT SEEMS abundantly clear that an official system of treatment for old-age pensioners under the Health Service is unlikely for a long time to come. We all admire the work of the various voluntary organisations in providing free treatment for the old people, but much more must be done. There are too many districts without the facility at all.

THE STRANGER

WHO IS the stranger calling upon chiropodists complete with visiting case, overall, etc., offering to lend his services for a few days? He declines to give any particulars about himself. According to

one report his work is of a high standard and he appears to have no ulterior motive of any kind. His strange conduct may be a matter of pride. Nevertheless, I advise a cautious approach to this stranger.

THE PATIENT WRITER GIVES IN

THREE YEARS ago a chiropodist acquaintance—one of the older school—commenced writing a chiropodial book. He has spent almost all his spare time in the effort. Now his confidence seems to have mysteriously left him and all those patient and laborious hours have been wasted. He refuses to publish the work. Properly vetted and edited, I am sure his work would have impressed. I am trying very hard to persuade him to think again.

INACTIVE

AS IS USUAL during July and August, activity in the chiropolitical world is

almost at a standstill. By the autumn, however, I am expecting matters to move with some speed.

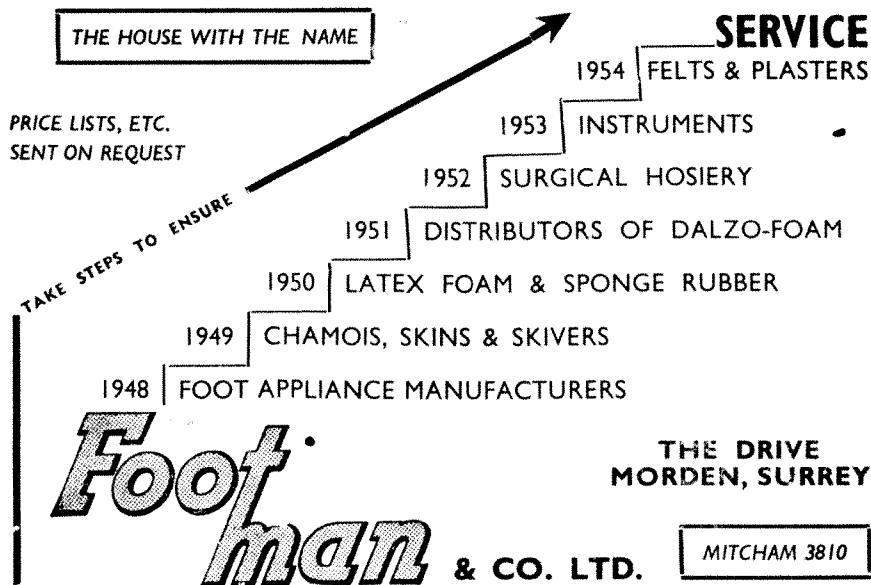
YOUR FUTURE DESCRIPTION

IF AND WHEN state registration arrives, under what description will you practice? Here are one or two possibles: "State Registered Chiropodist," "(Medical Auxiliary) Chiropodist," or just plain "Chiropodist." My preference goes to the last named. Someone suggested the description "Licensed Chiropodist." Heaven forbid! We have had more than enough of the wretched word "license."

NORMAL BUSINESS

THERE IS NOTHING in my reports from up and down the country to get excited about. Most established practices are busy but not overburdened with work. The more recently established practices continue to find the going rather hard.

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ABSTRACTS

From Our Contemporaries

Journal N.A.Ch. (U.S.A.)

Postphlebotic and varicose venous stasis resulting from grossly incompetent perforating veins in the leg may be corrected by wearing an air-pressure legging.

Incompetent valves in the main stem veins of the saphenous system may cause venous stasis, but the harmful effects can be remedied by high ligation of the main superficial venous trunk above all the branches. However, the stasis accruing from incompetent valves in the perforating veins and from the inflammatory reaction after femoroiliac thrombophlebitis is much more difficult to treat. Lymphedema of the leg may occur and, if the condition is unrelieved, pigmentation, subcutaneous induration, and ulceration are likely to appear.

- Attempts to overcome the stasis by external compression, sclerosing venous injections, and ligation of the incompetent perforators have serious defects and many of the severe conditions continue unchecked.

In other 350 cases of stasis, W. J. Merle Scott, M.D., has used a legging of inelastic material containing an inflatable rubber bladder, which is pumped up after the legging is donned. Not only is controlled and uniform pressure applied to the skin, but the pressure rises rhythmically with each contraction of the muscles on walking. Essentially, the legging is like a substitute for the deep fascia, placed outside the skin and subcutaneous tissues, and the powerful pumping action of muscular contraction compressing the veins and pushing the blood upward against gravity is applied to the superficial veins throughout the lower part of the leg.

The rubber bladder is inflated to about

35 mm. of mercury and, when inflated, should contain an air pocket at least $\frac{1}{4}$ in. wide throughout its length. The patient's application of the legging and method of inflation are checked to assure best results.

The swelling from postphlebotic or varicose stasis can be adequately controlled by the legging, but any inflammatory element must be treated before complete control can be achieved.

Hardened subcutaneous tissues and thickened corrugated skin do not benefit quickly from treatment with the pulsatile air pressure. After from six to twelve months of treatment, however, the subcutaneous induration softens, and the skin becomes smoother and more pliable. The nutrition of the limb is much improved; even the pigmentation lightens.

Postphlebotic and varicose ulcers in the lower leg are regularly healed while the patient is ambulatory. The granulated base rapidly assumes a healthy red appearance, granulations fill the concavity of the ulcer, and epithelium rapidly grows across the flat surface.

Ulcers with a hardened fibrotic base take longer to heal. If the base is directly on periosteum so that granulations cannot develop, a split-thickness graft is applied.

If infection is present, but not too virulent, the ulcer usually heals with use of the legging. For the more serious types, and quite often with fungous infections, topical treatment is necessary.

Rubber sensitivity occasionally occurs. A woven cotton bandage worn without stretch next to the skin is sufficient to correct slight sensitivity. For severe reaction, the rubber bladder must be enclosed in plastic.

Excess moisture is sometimes present, especially in conjunction with an eczematoid dermatitis. The legging increases the moisture and irritates the skin condition.

A cotton bandage next to the skin will absorb the moisture; in severe cases, dilute potassium permanganate soaks or gentian violet applications are used.

Usually the damage to the valves is permanent, and venous stasis will return if the legging is discontinued. After ulcers have healed, induration has receded, and nutrition has improved, the legging may usually be left off from 10 to 25 per cent of the time the patient is on his feet.

Current Chiroprody (New York)

A SCHOOLBOY ON CORNS

CORNS are of two kinds—vegetable and animal. Vegetable corn grows in rows, and animal corn grows on toes. There are several kinds of corn: there is the unicorn, capricorn, pop-corn, corn dodgers, cornfield, and the corn you feel the most. It is said, I believe, that gophers like corn, but persons having corns do not like to "go fur", if they can help it. Corns have kernels, and some colonels have corns. Vegetable corn grows on ears, but animal corn grows on feet, at the other end of the body.

Folks that have corns sometimes send for a doctor, and if the doctor himself is corned, he probably won't do so well as if he isn't. The doctors say corns are produced by tight boots and shoes, which is the reason why when a man is "tight" they say he is corned. If a farmer manages well he can get a good deal of corn on an acre; but I know of a farmer that has one corn that makes the biggest acher on his farm. The bigger crop of vegetable corn a man raises, the better he likes it; but the bigger crop of animal corn he raises the better he doesn't like it.

Another kind of corn is the corn dodger. The way it is made is very simple, and it is as follows—that is, if you want to know: You go along the

street and meet a man you know has a corn, and a rough character; then you step on the toe that has the corn on it, and see if you don't have occasion to dodge. In that way you will find out what a corn dodger is. He will tell you the rest.

Wisconsin Society Journal

From Annual Report of Committee on Economics:—

Fair and adequate fees are essential to preserve and increase the professional level of chiroprody so that it is always able to render more effective public service. Unless this is clearly realised, continuing economic pressures can insidiously depress the chiroprodist's position into creeping economic insecurity. To permit this to happen in any degree is to place much in jeopardy. Those in established practices need to look to the future with continued confidence that experience is a valued asset. Those in newer practices need more than the threat of disillusionment—they must not for a moment wonder whether their vocational choice of chiroprody was a serious mistake.

The public must be constantly shown through conscientious chiroprodial care that the profession merits an even higher level than its presently hard-won position of public and medical acceptability.

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QUERIES

Answered by F.A.D.

Q *Can you help by saying what in your opinion is the best material to buy for making metatarsal pads and what is the best way of determining shape and position? — G.J.*

A I could perhaps help you more if you gave full details of the case you have under consideration. The choice of material as well as the shape and positioning of a metatarsal pad is dependent upon the characteristics of the individual foot, the patient, and the condition which it is desired to rectify. To cite the numerous types of pads with their variations in material, thickness, degree of compressibility, size, shape, and application would demand much more space than we can give in this column, whilst of course the study of the fundamental principles which guide one's reasoning in these matters forms part of the basic training in chiropody both theoretical and practical.

In general one may say that choice of material is governed by factors which include:—whether it is desired to elevate (or obstruct the descent of) one or more of the metatarsal heads, or if it is desired to protect a lesioned area, or to supplement an inadequate cushioning of the metatarsal area and to absorb shock, or to redistribute weight bearing over a wider area to relieve overburdened points. The shapes of pads will be determined by such factors as the above considered in relation to the general structure and possible abnormality of the foot, and must be related to the curve formed by the metatarsal heads. The simple metatarsal pad may be skived with a short bevel forward and a long bevel at the rear; it is so placed as to allow the metatarsal heads to rest over

the forward bevel.

A considerable variety of materials are at the chiropodist's disposal for corrective and palliative padding, and in determining the method of application the patient's skin condition as well as any particular incapacity from general health or age should be taken into consideration.

Q *During my army service I attended a course in chiropody at a well-known hospital, and passed. I was a paid chiropodist in my unit and carried on with this for four years until being discharged through war wounds.*

I intend to carry on in this profession; what must I do to become a member of the Society of Chiropodists.—J. H. P.

A Thank you for your letter. You will probably know that the short war-time courses for battalion chiropodists or foot orderlies was not such as would be recognised as a qualification in civil life, the officially recognised course being one of a minimum of two years' training full-time. At the close of the war the government sponsored the full training of many ex-service men and made adequate grants towards their fees and maintenance. It is therefore a great pity that your decision was not made eight years ago, when you might have benefited by the arrangement.

The normal manner of entry to the Society of Chiropodists is by one of two ways: either by taking the full-time course which was recently extended to three years and passing first the intermediate exam and then the final exam, entitling you to membership, or by giving proof of having been in full-time practice as a chiropodist for six years and by taking the open public examination, which, if satisfactorily passed, will entitle you to membership and the letters M.Ch.S. A further examination for Fellowship may be taken under specified conditions and this, if passed, entitles one to the letters, F.Ch.S.

NOTES AND NEWS

Claim Dismissed

A WOMAN'S STORY of a visit to a chiropodist's surgery was described as "highly coloured and exaggerated" by Mr. Justice Streatfeild at Bristol Assizes recently.

He dismissed, with costs against her, a claim for damages by Mrs. M. C. Hall, of Swindon, Wilts., against a chiropodist of the town, Miss M. F. Chadwick.

Mrs. Hall claimed that as a result of negligence while being treated by an assistant to Miss Chadwick, she received a cut on her foot which became infected, that she had to have an operation, and that she was still left with a swollen foot and discomfort.

Saying that he was satisfied that proper precautions were taken, Mr. Justice Streatfeild said: "I do not believe that this qualified chiropodist (the assistant) over and over again operated on Mrs. Hall's foot with no preliminary hygiene at all."

Mr. S. H. Brown

A SHEFFIELD CHIROPODIST, Mr. S. H. Brown, died recently at Leicester Isolation Hospital at the age of 43, following what was believed to be the first operation of its kind to be performed in Great Britain. The operation, on his heart, was to place an artificial valve in the descending aorta.

Foot Deformities in Schools

CONCERN by the Scarborough deputy school medical officer over the increase in foot deformities among schoolchildren was expressed to Scarborough, Yorks., Divisional Education Executive recently.

The deputy school medical officer, Dr. Elizabeth Cameron, stated in her report that children in many cases wore their

shoes for too long a period when they had actually outgrown them.

Girls in secondary schools were a different matter; in many cases mothers could guide their children in the selection of shoes instead of allowing them to have what they fancied in the way of fancy footwear.

Grant Renewed

FOR THE FREE foot clinic, run by the Salvation Army, for old-age pensioners in Wembley, London, the Middlesex County Council has renewed its annual grant of £10.

Foot Survey

THE HALF-YEARLY REPORT of the Chief Medical Officer of Health for Somerset contains an appendix covering a survey of children's feet and footwear which was carried out jointly by C. & J. Clark, Ltd., shoe manufacturers, of Street, and the consulting orthopaedic surgeons to the Bath Orthopaedic Hospital.

An equal number of each sex of each age group from 5 to 14 years inclusive, from varying types of schools in the four largest towns in Somerset, were chosen as the subjects of the inquiry, and the feet and footwear of 1,207 children were examined by the surgeons in November, 1953.

The survey showed that five per cent of the girls were wearing women's shoes; out of 496 children wearing either new or moderately worn shoes whose feet were examined, 41 were $1\frac{1}{2}$ sizes short, 11 were 2 sizes short and 1 was $2\frac{1}{2}$ sizes short; ten per cent of all children examined were wearing shoes that were too long, 60 per cent too short, and only 30 per cent correctly fitted shoes.

CLASSIFIED ADVERTISEMENTS

The cost of Classified Advertisements in "The British Chiropractic Journal" has been reduced to 2d. per word, minimum 3/-; Box Number 6d. extra. Address: Advertisement Manager, The British Chiropractic Journal, 356-358 Kilburn High Road, London, N.W.6

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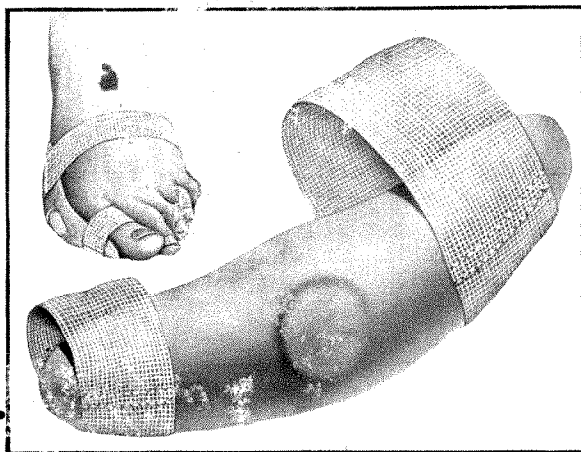
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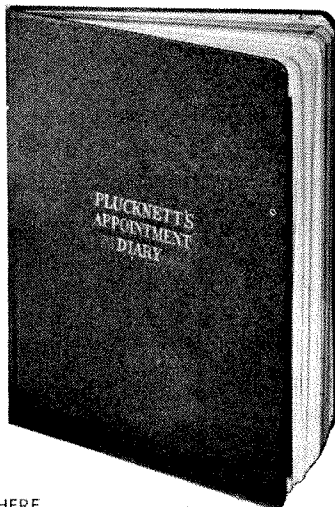
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DID THEY VOTE? By the time this issue goes to press the Society conference will be past history and the results of yet another annual election will be known. We wonder whether the soul of the Society has been sufficiently stirred to cause a high percentage of the membership to use its vote either in favour of or against those who have offered themselves as candidates for election to council. We hope so, indeed, for in the past years the proportion of members using their vote has been lamentable.

We have previously given our opinion as to the reason for this default and we have no reason so far to change it; we feel that it is because the average member does not know sufficient about the

nominees, particularly as regards their ideas, if they have any, as to what they visualise for the future development of our profession, its scope, its status and the methods by which they think it should be obtained. Are they prepared to lead on to greater things, or just to tag on and drift with circumstances? Are they prepared to make chiropody a vigorous progressive profession? It is not sufficient for men to be willing to become councillors on the assumption that they will do their best when they see what crops up, and a list of appointments held in a branch or in clinics is not adequate information about a candidate for those who know nothing else about the person.

We shall be agreeably surprised

if more than 30 per cent of Society members used their vote this year.

ANNUAL CONVENTION The annual convention of the Society is undoubtedly the most notable chiropodial event of the year and was billed for September 9-11 at Glasgow. Those members who were able to travel to Glasgow will no doubt have been well rewarded for their trouble, for as usual the convention provides an educational feast served by a number of very prominent medical men and members of our own profession, besides the social events where one may meet old friends and make new acquaintances. The publicity associated with events of this nature is of value to the profession generally. We wish we could say that this was a national convention at which all bona fide members of the profession were welcome, but for such an event it seems we must await the legal machinery which may decide who are the sheep and who are the goats. However, in view of the existence of the working party negotiations now proceeding between the Society and the J.C.C. under the jurisdiction of the Ministry of Health we do think it would have been a valuable gesture of goodwill if the Society had extended an open invitation to members of the Joint Council to attend the educational events of this 1954 convention.

SUCCESS IN CANADA At the annual meeting of the Canadian Medical Association at Vancouver in June a long struggle on the part of chiropodists to obtain the formal recognition of the Association was brought to a successful conclusion. As is well known by our readers, chiropody in Canada has enjoyed the legal recognition and the protection of law for a number of years, but the medical profession lagged behind with customary reluctance. However, at Vancouver a report by Dr. Wallace Wilson, chairman of the

ethical committee recommended the full recognition of chiropody as a profession ancillary to the medical profession. His report was based on a study of documentary evidence submitted by the Canadian Association of Chiropodists dealing with educational standards, training, clinical subjects and ethics.

Chiropody in Canada is practiced entirely on American lines and training is principally derived from the U.S.A. colleges. The profession is governed by the Chiropody Act which gives the definition of chiropody as:

The diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of the human foot, including the non-surgical treatment of the muscles and tendons of the leg governing the functions of the foot, or any one or any combination of said practices or treatments. No chiropodist shall use an anaesthetic other than a local anaesthetic.

And all this is now fully recognised by the Canadian Medical Association as being the proper scope of chiropody! This should act as a stimulant to the Society and the J.C.C. in their working party deliberations, as an example of what can be accomplished with determination and merit.

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REMINISCENCES

By J. McBain, Stewart, M.B.E.

REMINISCENCES and meditation, as a relaxation from our everyday routine, may, presumably, occupy a leisure hour in the minds of the majority of readers, especially those of the older generation.

They are the men, and women, who should, and can, best reflect upon the history of our profession and review, in the light of their experience, whatever progress has been made, together with the mistakes they have made, shared in making, or seen made.

It is to them that the younger generation of chiropodists must look for inspiration to guide them in the reconstruction of the existing policy, which has up to date proved ineffectual in attaining the solidarity, and higher professional status, which has been, and is, the objective of the most progressively minded men in the profession.

It is perhaps true to say that in no country has earlier, or better, opportunity been presented, to give a lead to our profession, and to remain in the vanguard of progress, than we had; but that opportunity has been frittered away, because we have never formulated an agreed policy, consistently supported by united effort.

It must be conceded that we are in an unenviable position, amongst our contemporaries, and other professions, because it is being left to others to set our house in order for us, according to their estimate of our deserts. It may justly be claimed that we have, in this country, men and women in our profession who will compare favourably with the best anywhere else; also that we have men who have devoted themselves so intelligently, and assiduously, to study, research,

and practice, that, so far as they are concerned, chiropody has been raised to a degree of efficiency, and utility, worthy of much higher recognition than it can yet claim in the field of therapeutics.

Notwithstanding this, however, it cannot justly be claimed that our profession here, as a whole, is worthy of any greater public confidence than that, so far, assigned to it, because—and here let us face facts—we have failed to unite in a determined and well-directed effort, to standardise our curriculum of training, to centralise our venue of examination and qualification, to close all surreptitious means of entry into the profession, and to assure a generally high standard of efficiency throughout. The result is that over a period of many years, the personnel of chiropody has become over-saturated by ever-increasing infiltration, from unreliable sources of training, to such an extent that, unless some drastic measures are taken now to eliminate this menace to the public, and the profession, little encouragement can honestly be given to any intelligent and ambitious young man or woman to enter the profession in the immediate future.

It is not my purpose to decry any sincere efforts, or such progress as has admittedly been made, by several prominent leaders in our profession whether the effort was on behalf of the profession as a whole, or on behalf of a section of it; but, if I must write with my usual candour, and even at the risk of offending some, perhaps many, who may differ with me, I do so in what, in my opinion, is the interest of the profession and its future. We are all entitled to our opinions, in matters mutually affecting us, or those in whom we should be interested, and the sooner

we learn to respect each other, at least to that extent, and pool the best for the good of all, the better for all concerned, not forgetting the public.

During the recent eclipse of the sun, I found myself musing over the past, present and possible future of chiropody; wondering where we could place it in the galaxy of professions.

Ours has never been entirely eclipsed, since early in the nineteenth century, Lewis Burlacher, by devotion of his personal skill to practice as a surgeon-chiropodist, enhanced its reputation; but many dark shadows have passed over it during the interval, not the least of which have been within our own memories.

I have never concealed my own personal views regarding the morass into which we have been drifting during the past quarter of a century. I have repeatedly pleaded for unity, and all that should go with it, as a policy to be adopted with a view to deserving, and attaining, genuine professional status.

At the same time I have not favoured any movement tantamount to placing the cart before the horse; by which I mean, 'Asking for increased status, before raising our standard of training, and qualification, consistent with our demands.'

I have, however, become accustomed to having my proposals vetoed.

It is on record that at a meeting of representatives of the I.S.Ch.; B.A.Ch.; C.A.Ch., and N.A.Ch., held at the College of Nursing, Henrietta Street, W.1., on February 13, 1937, I advanced the suggestion that the period of training should be increased to a minimum of three years. I got no support; but, on the contrary, certain representatives favoured periods of under two years. It is worthy of comment here, that, at least some of those who opposed extension of training then, have been, during the interval, most prominent in their claims for statutory recognition.

In my previous reference to infiltration, I exclude no organisation however numerous, and irrespective of its propaganda; not even the chiropodial section of the B.R.M.A., which many who should be able to assess the merit of a chiropodist's qualification know has failed in its anticipated purpose.

I am pleased to note that the Society of Chiropodists has ultimately decided to extend their period of training to three years, but is this not equivalent to locking the stable door after the horse has gone?

What has happened to chiropody during those wasted years, since 1937? What could our position have been, had the extended course of training been adopted then? Why is it that to-day we have so many chiropodists begging for posts, or working part-time, for money? Why is it that, under these circumstances, many good and experienced chiropodists maintain a flourishing private clientele and command economic fees, irrespective of which, if any, organisation they are attached to?

I leave these questions for the reader to answer.

Later on, 1945 I believe, at the instigation of the Council of The British Association of Chiropodists, we decided to form an entirely new, and authoritative, organisation of chiropodists, by fusion of what were, at the time considered to be the most eligible of the many existing bodies.

It was agreed, and understood by most, that, concurrent with fusion, each participating body of chiropodists, was to sink its identity in the new organisation, but it soon became manifest that, at least one organisation had no such intention, when their representative proposed that in place of fusion, the word absorption would be preferable. Although this amendment to the proposal was turned down at the time, subsequent events have proved that if fusion was the theory

absorption has been the practice, and to-day the Society of Chiropodists is the embodiment of the Incorporated Society of Chiropodists, and I suggest that it will be difficult for anyone to show in what respect, or to what extent, the latter has sunk its identity.

I do not blame those who have, so far, got away with that political dodge; I prefer to place the blame upon those, including myself, who allowed it, and even more so upon those who have continued to support it. Had we suspected then what was to be the future policy of the new Society, we might not have been so pliable, and we might have set a different course, by retaining for the new organisation the title British Association of Chiropodists, a title which I still consider more appropriate for a national body.

For the sake of anticipated unity, harmony and progress, however, we did honourably sink our identity.

Up to this point, all might have been well; but the best laid plans of mice and men, *gang aft a'gley*, and the actual aim of these who had taken the reins in the new Council soon began to unfold itself. In due course, the Council lost the services of most progressively minded men from the B.A.Ch.

The greatest weakness in their adopted policy, during recent years, has been their persistent refusal to meet in conference with others, whose policy in any way differed from theirs. Such conduct

suggested weakness, rather than strength and confidence in themselves.

Now, what they so persistently refused has been forced upon them by outside authority, and I still await evidence of their acceptance of the position with good grace.

In the foregoing, I have endeavoured to pinpoint some of the mistakes and miscalculations from which the chiropodial profession has suffered in the past; may I now, in conclusion, express the hope that the younger generation may profit from our experiences, instead of drifting along in the same rut and perpetuating the errors of their predecessors. Surely in the profession, there should be found a sufficient number of individuals to form a team capable of leadership, to remove the dead hand from control of its destiny, and not only allow, but encourage progress to be justified by the necessary higher standard of training, and selection of candidates likely to be suitable afterwards. I see no reason why the ground which we have lost should not be made up within the next decade.

I offer these reminiscences completely free of any ulterior motive. I have been successful in my profession and, having put a considerable number of years behind me, have no ambition towards leadership or administrative work. I have, however, the courage of my convictions and a vital interest in the future of the profession with which I have been so long connected.

HYDROPHILIZED IODINE GEL THERAPY

For Diabetic Ulcers

By Louis A. Alchermes, Pod.D.

DURING the past year many medications and techniques were investigated in the treatment of diabetic ulcers.

One of the most effective was found to be hydrophilized iodine gel, which is an elemental iodine in a free and un-

combined state of colloidal aqueous dispersion.

One of the primary factors in the treatment of any wound, regardless of origin, is infection control. Another important factor is the stimulation of circulation to the involved area.

The germicidal and stimulating properties of iodine have been recognised for years. Unfortunately, the irritative factors in iodine therapy have contraindicated its use in diabetic patients. Hydrophilized iodine gel was found to have eliminated the toxic effects while retaining the germicidal and stimulating properties of iodine. Its fungicidal activity indicated its usefulness in preventing secondary infections from complicating the ulcer picture. The low surface tension of this product permits more intimate contact of the medication with the wound. The ability of hydrophilized iodine gel to release instantly active "free elemental iodine" in a non-irritating and harmless manner accounts for its success in the cases reported herein.

The following method of application was used :—

1. Area involved was carefully debrided.
2. Then washed with sodium bicarbonate solution.
3. Hydrophilized iodine gel was applied by gentle rubbing actions.
4. It was allowed to be absorbed into tissues (app. 30 secs.).
5. Sterile gauze pad was then applied.
6. Protective pads were used where necessary.

In a series of six selected diabetic cases with ulcerations, five were completely healed in from three to sixteen weeks. The sixth case came for treatment too late for any known medication to be effective. Patients were advised to apply hydrophilized iodine gel locally whenever evidence of irritation or tissue

breakdown was present, until they could be examined by the doctor.

In the case histories which follow, reference is made to the unsuccessful results obtained with the use of "various accepted methods and medications." This phrase includes the use of the following therapeutic agents and technics.

Antibiotics (gram-positive and gram-negative).

Various unguents containing chlorophyll as the active agent.

Unna's boot technique.

Antiseptics such as gentian violet, metapen, etc.

Alcohol moist dressings.

Case 1.

Patient : L.C. Age : 70. Sex : Male.
History : Diabetic 2 years. Unilateral amputation left leg 1935. Ulcer on right foot—os calcis— $\frac{1}{4}$ in. diameter, originated April, 1951. During the period April, 1951, to December, 1952, the various accepted methods and medications listed above were used. Ulcer never completely healed.

Treatment : Hydrophilized iodine gel 2 per cent was first applied February, 1953. Patient instructed as to daily application. Ulcer completely healed in eight weeks.

Case 2.

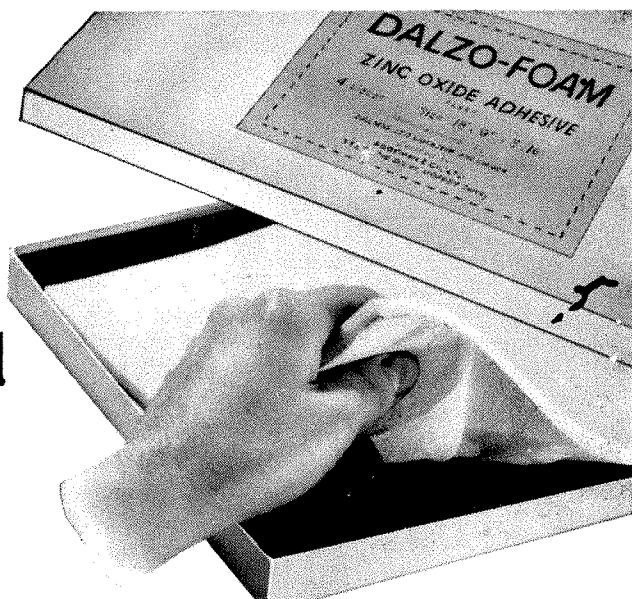
Patient M.W. Age 65. Sex : Female.
History : Diabetic 15 years. Circulation fair. Ulceration $\frac{1}{4}$ in. diameter, 2nd, 3rd, 4th metatarsal heads, plantar aspect, right foot. First treated March, 1950. Various medications used. No great improvement.

Treatment : First used hydrophilized iodine gel daily therapy in October, 1952. Ulcer completely healed—3 weeks.

Case 3.

Patient A.B. Age 49. Sex : Female.
History : Ulcer appeared February 20,

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1952. X-Ray showed demineralization of body structure. Sclerosis of peripheral vessels noted. Patient had ulcer $\frac{1}{2}$ in. diameter, 2nd, 3rd metatarsal head area—plantar surface bilateral. First applied other medications August 8, 1952. Patient appeared with cellulitis.

Treatment: Hydrophilized iodine gel therapy instituted September 11, 1952. Area completely healed December 18, 1952.

Case 4.

Patient P.S. Age 59. Sex: Female. History: Ulceration of heel 2 in. diameter. Nov. 19, 1952. Right foot.

Treatment: Hydrophilized iodine gel therapy immediately applied. Patient completely healed Dec. 11, 1952—3 weeks.

Case 5.

Patient I.C. Age 55. Sex: Male. History: $\frac{1}{2}$ in. ulcer, centre heel, plantar, left foot. Circulation fair. January 15, 1953.

Treatment: Hydrophilized iodine gel

treatment, completely healed April 8, 1953.

Case 6.

Patient J.W. Age 70. Sex: Male.

History: Ulcer 1st toe. Poor circulation. One leg amputated several years ago. Ulcerated toe in gangrenous state. Patient neglected to come to clinic in time.

Treatment: Tried to heal with hydrophilized iodine gel. After two weeks cellulitis still uncontrolled and widespread. Leg amputated. Therapy instituted too late.

CONCLUSION

Six cases of diabetic ulcers have been presented. Due to the results obtained with hydrophilized iodine gel therapy, even with these cases which had resisted all other previous treatments, this product is satisfactory and warrants further and more extensive use.

All cases treated for diabetes by physician. Diabetes under control. Systemic control of infection whenever necessary.

THE WEAKFOOT CONCEPT—Part VI*

by L. F. Schreiber, F.A.A.C. (Hon.) F.A.C.F.O. and
H. W. Weinerman, D.S.C.

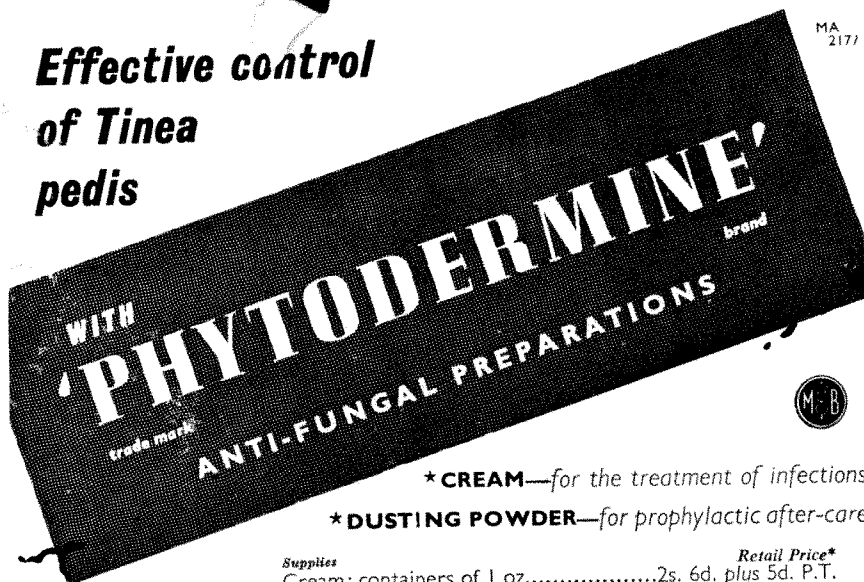
IN practice, the law of locomotor stability takes into account the functional ability only of the locomotor mechanism. It is not concerned with morphological characteristics, such as weakfoot, *per se*. It is concerned chiefly with elevating the motor capacity index, the pivotal control factor in *podostability*. In this sense, the etiologic basis is functional while at the same time taking into consideration any coexisting pathogenic background of the general system.

Among those chiropodists whose practice is devoted largely to the management

of functional disorders, particularly either the weakfoot type or the short first metatarsal, evidence of a substantial nature lacks to indicate association of architectural morphology with functional instability (*podoinstability*), when backed by clinical findings of disability or pain syndromes apart from architecture. On the contrary, clinical evidence indicates that *functional strain* and consequent instability predominate in such cases. Moreover, the great majority of cases of *podoinstability* appear to have their origin on a much broader and more general etiologic basis or synthesis, *purely individual*

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in each case, and not subject to any architectural classification.

CONCLUSION In this paper the human foot is considered as a *basic physiologic structure*, a functional unit which is subject to a large variety of exogenous and endogenous etiologic factors having little or nothing to do with weakfoot morphological characteristics, the latter playing but a purely incidental and secondary part in the concatenation of events leading up to dysfunction. Podobiomechanical and other suitable therapeutic procedures, properly and adequately applied, will bring about rehabilitation to the maximum possible extent, and one ought not judge the results on the basis of the weakfoot concept as having any bearing on the condition. Weakfoot has been treated for many decades upon the false premise that when pain is relieved the objective is achieved, *natural pronation remaining static in the process*, while in actual fact locomotor stability has been restored by elimination of etiologic factors foreign to the weakfoot posture.

Every scientific hypothesis or concept is founded upon a generalisation resulting from the accumulation of technical data to lend it support. However, since myriads of particulars are required to reach up to such a generalisation, subsequent investigations and observations are likely to bring to light new findings, together with the discovery of former shortcomings and flaws not apparent in the original hypothesis. In line with subsequent disclosures, scientific method then demands modifications of the former concept or hypothesis in terms of the newer developments.

Thus it is that many a concept contains a grain of truth that provides an intellectually agreeable groundwork, yet far from acceptable on a practical working basis. The Morton syndrome is a good illustration of this point, as proved by the Canadian Army Foot Survey. On the

other hand, the weakfoot concept has escaped the fate of Morton's theory due to a paucity of observations of the inherent weaknesses of the concept in its practical aspects. Textbooks and countless articles have upheld it by repetitious recital, aided and abetted by those who were "indoctrinated with habituated forms of thinking in the realm of the scientific."

The intensive studies and clinical observations on the part of Harris and Beath bear out their contention that the short first metatarsal "has never been submitted to adequate study" by investigators; adding, furthermore, that association of the short first with foot disabilities may "be the result of coincidence." Similarly, the contention has been made by some members of our profession, but not borne out by extensive investigation, that weakfoot is not a pathognomonic entity, even if the conclusion is arrived at in cases where it is superimposed over Morton's syndrome. In any case, all theorising in the past has not given us Ariadne's thread to lead us out of the labyrinth.

It is obviously more vital, therefore, that we deal with reality in the case of the functionally impaired foot and concentrate upon restoring its *motor capacity index* to optimum. To state the problem in another way, it is infinitely better to be disillusioned about morphological appearances presented by weakfoot than to mislead the patient and be confounded on just what is being attempted in the way of therapeutic objective. We are well aware that in the general practice of medicine or surgery the primary purpose is to improve functional capacity and restore better health rather than to attempt to change morphology, certain notable conditions excepted. The clinician need not be deterred, on this basis, from seeking the physiologic explanation for this approach to replace the fallacious one of attempting to effect a cure for something



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that never existed and has been misunderstood from the beginning.

In the investigation of the weakfoot concept, we have shown that architectural structure or morphological distortion or deformity does not present true criteria upon which to sustain anything but the operation of biologic, physiologic and biomechanical laws, including, for the most part, Wolff's law and Davis's law. Nor has radiology presented a case in defence of the concept, since radiographic interpretations are unrelated to the basic issue of functional ability and capacity of the human foot, which eludes all attempts to pin it down to human preconceptions. To this we may add the admonitions by Whitman and Schuster to regard the foot as a functional, rather than as an architectural or morphological, unit. All of this adds up to the age-old problem of structure (morphology) versus function (capacity for work). On the basis of the evidence herein presented, we rest our case on the latter.

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MISGIVINGS

By G. Stanley Mercer

CHIROPODIAL history is being fashioned. We know that through the agency of the Working Party Committee, sponsored by the Ministry of Health, the future status of the chiropodial profession and allied medical auxiliary services is being worked out.

By now, I imagine, the profession's spokesmen on that committee have gained some idea of the shape of things to come. I do not envy them their tasks. Theirs is a responsibility which will tax to the full their initiative. Happily the profession's chosen spokesmen are men of brilliance and wide experience. Happy also is the fact that they do not necessarily see things through the same spectacles. Indeed, there is a divergence of opinion over many of the major issues they have to deal with. This is all to the good as it brings to light all the snags as well as the advantages.

This is an appropriate time to analyse some of the difficult problems the profession's representatives will have to face up to. First and foremost, they will know that many of us possess misgivings about the advantages of regulation by a State Register, which embraces all sections of medical auxiliary services. It is held by many, and I am certainly one of them, that by virtue of its great growth as compared with the other services the practice of chiropody should be regulated as an entirely separate unit. The profession's spokesmen should, in my view, press this point for all they are worth. Even so, I doubt very much if they will succeed. The forces against separation will, I fear, be too powerful for them. For example, we all know that the Board of Registration of Medical Auxiliaries is

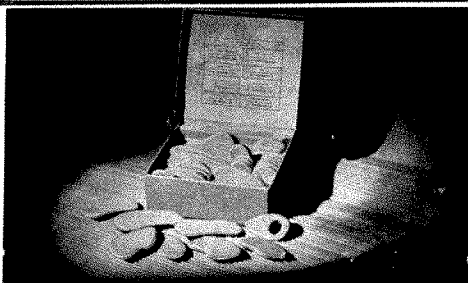
anxious to obtain legislation for all medical auxiliary services under the one act and authority. This viewpoint reflects also the viewpoint of the B.M.A. Influences of this magnitude are not easily overcome.

And what about the scope of chiropodial practice? Will the profession take kindly to being pinned down by legislation to that definition at present prescribed by the B.R.M.A? Let us be honest with ourselves about this delicate and highly important matter by asking the blunt question as to how many members of the Society are operating strictly within the narrow confines of the definition?

If its terms were rigidly enforced I venture to suggest that a great number would be called to account. It is of little consequence to turn a blind eye to small irregularities of this nature as matters stand at present, but under the authority of legislation few would risk the penalty of such transgression.

The last, but certainly not the least, subject I should like to touch upon is who will qualify for automatic inclusion on a State Register and who will not? Opinions are divided on this point. Members of the Society and Joint Council naturally hope that the privilege will be confined to them, but very few expect it. Neither do I. It is my convinced opinion that every established chiropodist who has been practising for eighteen months or perhaps two years, will qualify for automatic inclusion on the first register. The remainder will no doubt be required to pass an elementary examination specifically prescribed for the purpose.

Negotiations are likely to be long and difficult and all we can do now is to wait patiently for developments.



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GLASGOW CONVENTION

THE SOCIETY of Chiropodists held its 1954 Convention at Glasgow during the three days 9th to 11th of the month.

By usual standards the attendance was rather below normal. This must have been disappointing to the local organisers, as everything possible was done to attract members. Indeed, the Scots' reputation of an organising thoroughness was very evident.

It must have been disappointing, too, to the manufacturing firms who staged such an attractive exhibition. At best these shows must be costly and when the attendance is small heavy losses are involved.

I have always maintained that exhibitions of this kind should be sponsored by the trade and designed to attract all chiropodists quite regardless of the qualification they may hold.

I predict that this reform is likely when the profession becomes state registered, as seems probable in the not very distant future.

FEWER STUDENTS

ACCORDING to reliable information, there is some concern about the decline in the number of students being enrolled. The extended three years training period is the most popular explanation, but the view has been expressed to me that this

will alter overnight when the profession is blessed with the hallmark of state protection. Personally, I have an open mind about it, as if I was a youngster considering the practice of chiropody as a career I should not be very impressed with the scope of practice permitted as compared with the curriculum and time length of training.

Everyone engaged in the profession, is eagerly looking forward to the day of its protection, but before that time arrives we must surely be careful to make it really attractive.

PRACTICES ERRATIC

"AN OCCASIONAL RUSH" is the best that can be said about practices at the moment. Some chiropodists report the good patch here and there, but far too many, particularly the newcomers, continue to find the going very hard.

FEES

AT THE risk of being charged with raking up old stew, I must once again bring up the subject of professional fees. The question has reached serious proportions and warrants the closest attention of the chiropodial controlling organisation. Fee-cutting is rampant in almost every district throughout the country. Unless it is checked, patients will very soon be receiving treatment for next to nothing. It is a subject which can only be effectively tackled by the local branches of both organisations.

ABSTRACTS

From Our Contemporaries

Sante Publique (Paris)

ACCORDING to Professor Toubert the two world wars, plus those of Korea and Indo-China have evidenced a great increase in the number of wounds in the lower extremities. He divides them into three categories:

- (1) Lesions of the foot sustained by parachutists, studied during the last 10 years.
- (2) Frostbite of the foot, known from all time, but particularly during the 1914-1918 war, one form of which was known as trench foot, when more than 100,000 cases were observed. In 1944-1945 some 10,000 cases were noted in the Rhine/Danube Army and in 1950-1951 60,000 cases were treated in Korea.
- (3) Wounds caused by explosion of mines laid just beneath the surface of the ground. At certain moments in Italy and Germany such wounds reached 80 per cent of the total and in Indo-China such cases were met with daily.

Those in the first category were dealt with by normal methods; and those in the second category may be treated by administration of vitamin B combined with infiltrations and injections of Novocaine as demonstrated by Leriche, whilst category No. 3 belongs to the surgeon specialist who during the war became familiar with this type of wound, whilst civilian chiropodists may still encounter and have to deal with more or less distant after-effects.

Journal N.A.Ch., (U.S.A.)

CHRONICALLY soft, peeling, lustreless, easily broken fingernails may improve with gelatine therapy. Dr. Terence Lloyd

Tyson, of New York City prescribes 7 gm. daily of a commercial gelatine dissolved in water or fruit juice. In 10 or 12 cases natural firmness and consistency of the nails returned and white spots vanished within thirteen weeks. Better growth of hair and eyebrows or of brittle toenails was also noted in several instances.

TOTAL INVOLUTION of cutaneous carcinomas may be accomplished with topical applications of podophyllin. Dr. Maurice Sullivan of Johns Hopkins University, Baltimore, reports that this treatment destroyed 19 of 25 lesions within ten days to three months. Of the other 6 cases, 5 could not be observed after treatment, and results with 1 were considered poor. The treatment schedule was varied, but ten to twenty applications, in three weeks is probably a good working schedule. The resin is applied topically as a 25 per cent suspension in mineral oil or a 20 per cent solution in alcohol. While podophyllin does cause some injury to normal tissue, these effects seem to be reversible.

A PAD that simulates the ground may be used in the baby's play pen to strengthen leg and foot muscles.

The American Indian's graceful in-toeing gait is the result of a normal physiological response to rough terrain. Urban infants learn to walk on flat, smooth surfaces that do not develop the intrinsic leg and foot muscles. When the baby first stands, the legs are weak. If the ground surface is smooth, the child separates the feet and turns them out to get as broad a base as possible. This throws the weight on the longitudinal arches, everts the heels, and thrusts the heads of the astragali medially. Flat, pronated, weak feet result.

The habits of standing and walking acquired in infancy may last for life.

Infants able to develop foot and leg muscles according to physiological principles will have strong, well-balanced feet.

Mayrice H. Herzmark, M.D., of the Veterans Administration, Washington, D. C., describes a pad for the play pen which simulates the ground. The pad is made of sponge rubber with knobs. The knobs are $\frac{1}{4}$ in. high with diameters of $1\frac{1}{4}$ in. at the base and are staggered $\frac{3}{4}$ in. apart. When the baby's foot touches the knobs, the toes make reflex grasping movements; the foot cannot pronate but tends to invert.

FUNGI gain entry through the macerated skin between the toes. Early symptoms consist of an intense annoying and burning sensation. Examination discloses deep fissure of the skin in the interdigital spaces. Redness and exudation indicate the presence of inflammation. Microscopic examination reveals the presence of the causative fungus. If left untreated the infected area tends to spread, involving the plantar surfaces.

Due to the thick epithelium these lesions are characterised by deep-seated vesicles. In acute cases a thick, colourless liquid escapes when the underlying skin is removed. The appearance of this ulceration is a beefy red. In many cases hyperkeratosis is present. Some vesicles open spontaneously and become covered with a yellow, greyish crust.

The skin in these cases has a low resistance to secondary invasion by streptococci and staphylococci and in some instances such infection is followed by lymphangitis and thrombophlebitis. Penicillin offers an effective form of treatment for such mixed infections when given intra-muscularly or orally because it tends to eliminate the bacterial infection, leaving the fungus invasion to be treated. We have found that treatment

time can be markedly reduced with penicillin.

THE USE of compound tincture of benzoin is effective as a protective coating for ischemic extremities, in which gangrene is threatening because of an impending break in the skin. Ointments such as wool fat, cacao butter or olive oil are not protective agents and often do not prevent gangrene. They are of value in softening excessively dry skin. It has been found that a better protective coating is obtained for this purpose if compound tincture of benzoin is used in a more concentrated form than that described in the Pharmacopeia of the United States. The alcohol is permitted to evaporate from the tincture as ordinarily made up until one half of the original volume is left, thus, a more concentrated preparation is available. Evaporation is accomplished by placing 80 to 100 cc. of the compound tincture in a 100 cc. beaker and permitting the alcohol to evaporate spontaneously—it takes from 24 to 48 hours for the volume to be reduced to one half.

W. B. IGNATOFF, D.S.C. quotes the following as psychotherapeutic methods said to be effective in curing warts. He believes such means to be less effective when applied to the foot than to other parts of the body . . .

1. Pressing or rubbing the wart with a piece of apple or pork and then throwing away or burying the material. The warts are expected to disappear when the material used has rotted. The stage of the moon is often considered an important factor.

2. In North Africa the warts are exposed to lightning and magic incantations.

3. The blood of a hedgehog applied to the wart is listed as a cure.

4. Mark Twain relates the discussion

of Tom Sawyer and Huck Finn about the relative merits of using "spunk water" on a wart in the middle of the woods at midnight as compared with burying a bean, half of which is covered with blood of a wart, at a cross-roads at midnight in the dark of the moon.

5. Disposing of a dead cat in a graveyard at midnight where someone who was wicked is buried has been recognised as a cure for warts.

6. The application of castor oil, iodine, bleaching solutions, saliva, urine, or the juices of various plants and weeds all have their advocates.

7. Mild electric shocks, saline injections, painting warts with any coloured solution, using coloured lights or noisy machines also are credited with curing warts.

8. This unending list should also mention the waving of magic wands, the wearing of magic ribbons, buying the warts from the patient and outlining the part with the wart on a piece of paper and then burning the paper.

Chiropody Review (London)

THE FOLLOWING is taken from *The Doctor Notes* and is obviously a cry from the heart:

It is gratifying to find that present at the British Medical Association Meeting in Glasgow was a very illustrious physician who taught me medicine when I was a boy. Age seems to have thinned his hair a little, and maybe he stoops somewhat, but in his presidential address, which was widely reported in the Press, he has not lost his old cunning to hit the nail on the head. He points out that the circumstances of medical practice as instituted and encouraged by the National Health Service result in a lowering of the standard of medicine.

Doctors no longer have the time to give to their patients which they formerly gave, and which was essential in order that a good standard of medicine should be practised. The fantastic increase in the number of trivialities for which patients present themselves, the never-ending stream of certificates that must be signed, the innumerable communications that reach him from Committees and Councils, all these things are leading towards a decline in the practice of medicine. They are not, however, the only things.

The psychological impetus of the National Health Service on a profession, which by its very nature demands an individualistic turn of mind, because both patient and doctor are individuals, has been such that the finer minds in the profession are so disappointed that their tongues and their pens remain still with sorrow for the future.

Frequently enough a small caption appears in the "Daily Press" regretting the demise of the patient-doctor relationship, but such small paragraphs hardly do justice to the immensity of the breach which has been perpetrated in our generation, all in the name of "Welfare."

Let chiropodists take note, especially those whose greatest ambition for our profession is to seek its destiny within the limiting confines of the National Health Service.

Revue de Podologie (Paris)

THE JUNE issue contains the following interesting note concerning the emblem of Pope Boniface II (1389-1404) which consisted of a figure with a bear on its head and two cubs at its feet on which appeared the following words "Ici commencent tous les maux." Perhaps the whole chiropodial family may consider the learned saint as a great forerunner and its patron-saint, says the writer.

NOTES AND NEWS

No Assault

REFERENCES which, he said, had been given him in three different countries, were produced by Mr. A. L. James, a chiropodist of Kilburn, London, when he appeared recently at Willesden Court.

He pleaded not guilty to a charge alleging that he had assaulted a police constable in the execution of his duty, and after hearing evidence the magistrates dismissed the case.

Study of Foot Troubles

A £100 PRIZE has been awarded by the South-West Hospital Regional Board to Dr. M. Wynyard, of St. James's Hospital, Balham, London, for his report on a specialist study of foot troubles.

No Matching Feet

LADY BARNETT, who has achieved fame as a television personality and is a qualified doctor as well, told an audience of more than 800 holiday-makers at Skegness recently that there was no doubt that people had one foot bigger than the other and it was important when buying shoes to try on both.

She was a guest at a footwear industry brains trust in Butlin's Holiday Camp, at which the chairman was Mr. Francis H. Kelly, a member of the council of the Footwear Manufacturers' Federation.

Foot Health Convention

A FOOT HEALTH CONVENTION will be held at 6.30 p.m. on November 1, 1954, at the Caxton Hall, Westminster, London. The subject for discussion will be, "Is Bad Fitting the Cause of Foot Trouble"?

Speakers will include Mr. C. E. Kemp, F.Ch.S., principal of the school of

chiropody at the Chelsea Polytechnic, Mr. C. K. Rudkin Jones, of H. E. Randall Ltd., Mr. J. F. H. Hinton, of Selby Shoes Ltd., Miss Enid Dams, public relations officer of Lotus Ltd., and Miss Iris Ashley, of the *Daily Mail*.

New Foot Clinic

A FOOT CLINIC for old age pensioners was started by members of Bromley, Kent, section of the British Red Cross Society on the first of this month.

The welfare officer of Bromley division of the Red Cross said recently that they had been asked to start the clinic by the Bromley Hospital, who thought that such a clinic was badly needed. Help will be given voluntarily but because the service does not come under the National Health Service equipment will have to be bought and the chiropodist will be paid.

Part of the cost is being paid out of the section's own funds but people receiving treatment will be asked to pay a small sum towards the cost.

It is hoped that in the future it will be possible to take a ground floor room for the clinic but until more money is available for the scheme that has been found impossible.

Caravan Consulting Room

GLOUCESTERSHIRE Foot Health Week, which is now in progress and ends on September 23, has been organised by the Gloucestershire County Health Department in conjunction with the Foot Health Educational Bureau.

The main exhibition which was fitted into a caravan and has been touring the county included a corner consulting room for the chiropodist. The firms who lent

material for children's section of the main exhibition included James Southall and Co., Ltd., who showed examples of

Start-Rite shoes. Parker Shoes Ltd., Saxone Shoe Co., Ltd., C. & J. Clark, Ltd., and Softa Step, Ltd.

QUERIES

Answered by F.A.D.

Q *Can you tell me if the type of infra-red apparatus generally sold for home use is essentially different from professional models?—L.W.*

A The home-use I.R. generator may be regarded as the baby brother of the professional models which themselves vary very greatly in build, appearance, strength and capacity as do most members of a family. The small types may be said to be useful if properly employed within the limits of their type. The difference between the small and professional models is quantitative and qualitative; quantitative because the output is limited by the wattage of the generator and qualitative because with the home types naturally one cannot vary the element used in the same way as may be done with the larger apparatus used in hospitals, for it will be understood that there are many different types of elements in use, which vary as to construction and material employed and the quality—i.e., the band of wavelengths emitted—varies according to the substance of which the resistor or element is made and the amount of current passed through it.

A hot water bottle emits I.R. rays and, like electric heating pads, electric irons, and non-luminous I.R. lamps, emits the longer wavebands, which Kovacs puts at 15,000 to 120,000 Angstrom units. The shorter wavebands are obtained from various sources such as the sun, incandescent lamps of various types, arc lamps varying according to the composition of

the electrodes used, and specially constructed infra-red generators withstanding high temperatures. The latter, used with special filters, may be controlled to emit wavelengths no longer than 15,000 Angstrom units.

In principle the longer the wavelength the more superficial the penetration, and those emitted by the non-luminous sources are considered to have a maximum penetration through the skin of up to 2 mm., whilst the shorter wavebands may penetrate several millimetres more than that.

It will be easily seen, however, that the amount of heat generated in the tissues may vary with the part being irradiated as also with the rate of blood flow of the individual, for it must be remembered that the blood stream constantly carries away some of the effects and acts as a cooling system.

When greater penetration is required for the direct treatment of deep tissues one has recourse to diathermy and short-wave therapy, which is another story.

The amount of mains current consumed by small infra-red lamps varies from 50 to 300 watts and the average model used by chiropodists uses 500 watts, whilst the larger hospital models may use up to 1,500 watts, according to Kovacs.

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LETTERS

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal.

SUGGESTED FEES

Sir,—Regarding the controversial matter of fees, it would seem that many practitioners do not really know just what to charge and are simply shooting, often badly, in the dark.

Might I suggest for general consideration the system I have adopted with success for some time? I have fixed a fee of 7s. 6d. per attendance for work on both feet, and 4s. if on one foot only. I endeavour to confine the work done to a period of not more than 45 minutes.

This gives the patient a fair treatment and enables sufficient work done to justify the trust of the patient, and if necessary to give temporary relief to all conditions that cannot be completed in the one session. I find that if required, the patient will readily attend again. If called upon to visit the fee is 10s. 6d. However, in the latter case when the patient is both bedridden and say an old age pensioner in obviously poor financial circumstances I usually make an assessment on the spot of what I think the patient can afford, frequently as low as 2s. 6d. I might add that I strongly discourage visiting except in a deserving case.

From 9.0 a.m. to 4.0 p.m. allows scope for ten sessions and this should provide a reasonable income for at least the majority of chiropodists with a fair margin for one or two slack days. After all we can't all practise in Harley Street at 40s. a look!

This avoids having to charge upon either a time factor or on an often incorrect assessment of the value to the patient of the work done. Sufferers do not appreciate cheap fees, as they realise, generally by painful experience, that the

work done is invariably of a similar standard, and this latter is often only too true!

Let us have other views about this, but please let them be constructive and reasonable.

JOHN F. COLE, M.S.S.C.H.

Pontnewydd.

STILL TIME

Sir,—I congratulate you on the excellent editorial in the July issue. This problem should have been tackled by the profession several years ago, but there is still time for members to help themselves if they wish.

Registration will be a great step forward, but will not put more money into the pockets of our patients, and although we sympathise with them, it is about time that we now felt sorry for ourselves.

If the reason for keeping to a low fee, is fear of competition, it seems rather dishonest to wait for a "closed shop" before venturing to charge a little more.

I am of the opinion that the majority of patients would prefer to pay a little more for a good job well done, than receive hurried attention and poor materials.

We realise that chiropodists who undercharge for their services are valued accordingly, and do nothing to raise the status of the profession.

If any chiropodist cares to give a thought as to his income on retirement, it may be a little disturbing to him, and although he may prefer to keep on working, we are never sure of good health, and the hands are rather apt to get a little shaky by that time.

In conclusion, I think your definition of the standard to be our goal is perfect—"that which, given a normal week's work, would provide a professional man and his family with a dignified existence."

Wells.

J. W. GEORGE, M.Ch.S.

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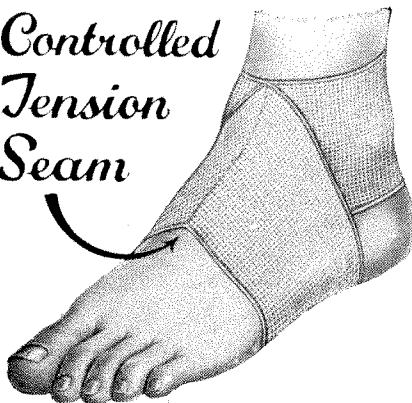
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CHIROPODIAL ASPIRANTS We frequently receive inquiries from persons interested in taking up chiropody, and one may say there is one feature common to the majority of them: they start off convinced that there is but one way of doing the thing properly and that is to take a correspondence course in the subject and thereby obtain a "properly registered qualification." Some are so ignorant of chiropodial affairs that they are unaware of any other port of entry to chiropody and are surprised to learn of years of struggle to create a profession, recognition of certain bodies by the B.M.A., the Cope Investigation Committee and its conclusions, the approval of the Society of Chiropodists and the Joint Council of Chiropodists as qualifying bodies by the Ministry of Health, and the present negotiations of the working party appointed to discuss with the M.O.H. the conditions of employment under the National Health Service and a basis for state registration. They are surprised to learn that the recognised schools are giving full-time students two or three-year courses of theoretical and practical training and that these students are required to pass two examinations under strict public examination conditions. Some seem to want it all done

by their own fireside while they carry on some other job in the daytime, exams, and all.

When one remarks that if everything a chiropodist has to learn can be acquired from a correspondence course in a few months' evening study then all these students doing a two or three years' full-time course of training are just plain foolish, the daylight of reason begins to dawn and the inquirer starts to realise that there is a side to chiropody with which he has been hitherto unacquainted.

One young married man came to see us only last week with genuine enquiry in his mind and a brochure in his hand about which he entertained some doubts. We could not help him regarding that matter but we were able to give him fuller information than he possessed about chiropody as a profession worthy of the name. We gave him a list of schools approved by the Society and the Joint Council, and copies of professional journals; we gave him an idea of fees required by official schools, discussed with him the status of chiropody, its recognition by the B.M.A. and what we hoped for in the future, its status in other countries and the weaknesses of our present position in this country; we told him of the Ministry's interest in

chiropody and all other auxiliary medical services. He particularly stressed that he wanted to do the thing in the right way and his idea was to get a post in a hospital. He had thought he could do all the necessary study in his spare time and then qualify in practical chiropody in one week. We told him that legally he could set up as a chiropodist either with such training or without it, but that the Minister of Health had decreed in the not far distant past that only those who had done a course of full-time training of two years' duration and had successfully passed the appropriate examinations could be considered eligible for employment under the National Health Service.

THE HUMAN ELEMENT Now the young man referred to above was a normal decent fellow; he was employed commercially but lacked opportunity for promotion and felt he was at a dead end. Chiropody appeared to him as a heaven-sent opportunity of securing an excellent income with a moderate amount of preliminary study and outlay. The idea of a two or three years' course, however, amazed him; he had not reckoned with any such possibility and further confessed that he could not meet the financial obligations. "Who is going to look after my wife?" he asked. He added that he thought it was not at all right that he who "was interested in making chiropody his profession" should be unable to study it fully because he could not afford it. We reminded him that there were many people with ambitions which they could not fulfil and that we all had to limit our desires to the extent of our purses; besides which, before he could state that he was really interested he would need to make closer acquaintance with the curriculum which he could

obtain from one of the schools mentioned and get an idea of the effort he would need to put forth in the course of his studies.

We felt a strong sympathy for this young man and we hope that, if he eventually feels that he must become a chiropodist he will find the means of doing so in a manner which will permit him to find his place in a hospital according to his wishes. At the same time we feel that he was surprised to note the scale of salaries for such posts; we have an idea that he had nursed much higher notions of income from chiropody, as did obviously our correspondent in this month's query column.

We wonder, now, will he perhaps decide to go the cheap way and, pushed by financial circumstances, stifle his ethical desires? We hope not. It is a strange reflection on the so-called welfare state that in some quarters a mentality has arisen which deems desire to be the sole prerequisite to acquisition.

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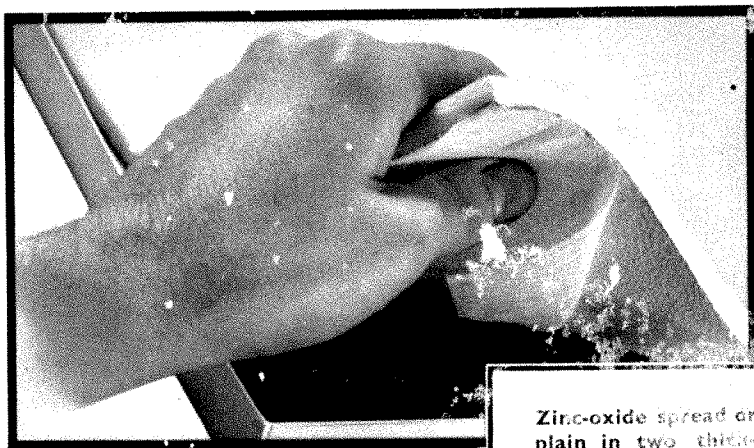
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Trilene Analgesia in Chiropody—Part I

By T. G. Fleming, M.Ch.S., M.R.I.P.H.H.

CHIROPODY during post-war years, as a profession and as a branch of medical science, has emerged into the light of public opinion. Within the confines of the profession we have several recognised authorities on different aspects of our work. Yet, strange to say, the problem of pain and its relief has found scant attention within the pages of chiropodial literature.

That upwards of 90 per cent of all our patients are satisfactorily treated in a painfree manner says much for the initial training we received as students. However, "upwards of 90 per cent" must never be confused with 100 per cent, and it is with this pain-conscious residue in mind that this article has been written.

The older chiropodist is often heard to put his or her faith in sharp scalpels, proper skin tension, and correct cutting technique. These basic tenets of operative skill still remain but they are not a complete answer in themselves. We have a number of post-operative analgesic dressings of which Rossignol and Holliday, in their excellent pharmacopœia, mention twelve. Under the heading of anæsthetics, the same authors mention ethyl chloride and benzocaine. The ethyl chloride spray, in my hands at least, has always proved rather a disappointment; that it is an efficient local analgesic for lancing areas of soft tissue I have no doubt, but as an analgesic when operating on nails and certain varieties of helomata it is found to be sadly wanting.

The remaining drugs mentioned in the literature more properly defined as anodynes and antipruritics. Amethocaine hydrochloride and cinchocaine hydrochloride, while being effective agents in contact

with mucous surfaces, are found to be practically useless in contact with the skin of the foot.

More recently, ung. xylotox and xylocaine have been brought to the notice of the profession, but again the consensus of opinion points to their use as post-operative dressings.

Briefly, then, the problem is still with us: that there is no really suitable analgesic agent that the chiropodist can employ when operating. To fulfil our needs, the ideal analgesic would require to satisfy the following criteria:—

- (1) It must be harmless to the patient.
- (2) Its full effect must develop rapidly.
- (3) It must be easy to administer.
- (4) After the initial cost it must be relatively cheap to use.

Careful search of available literature has not as yet revealed any simple "Dab it on and wait two minutes" type of drug, but it has revealed four possible pathways out of our dilemma. Unfortunately the first three must be passed over as unsuitable for chiropodial use. They are:—

(1) *Anæsthesia by hypnosis.* This method has been successfully employed on suitable types of patient. Unfortunately, however, the attendant risks to the mental health of the patient are so great as to rule out this method in chiropodial practice.

(2) *General anæsthesia* (by means of a nitrous oxide/oxygen apparatus). This is the simple dental-gas outfit, a very tempting method but unfortunately fraught with a number of snags for the unwary. In any case its use in chiropody is comparable to using a sledge-hammer to open a child's toy bank.

(3) *Local analgesia by injection.* This

appeals to many chiropodists but it is not such an innocuous method as it appears. For example, the patient showing symptoms of anoxæmia under nitrous oxide/oxygen anaesthesia can readily be resuscitated by the administration of oxygen. The converse picture is not so.

Consider the occasional patient with an idiosyncrasy to procaine hydrochloride a few minutes after the injection. We can have a very sick patient in the chair, closer to death from convulsions than we would perhaps care to admit. Since all local analgesics are convulsants, the reasonable treatment would be an intra-venous injection of pentothal, plus administration of oxygen. A muscle relaxant might even be necessary, with all its attendant fuss. After due thought has been given to the matter, most of us will agree with the Society's prohibition on "the use of local anaesthetics by injection."

Of the three methods so briefly reviewed, nitrous oxide/oxygen anaesthesia is undoubtedly the safest technique. Up to now we have dismissed topical analgesics, injection analgesics, analgesia by hypnosis and general anaesthesia, leaving as our only course general analgesia.

Since 1933 it has been the practice of midwives to use gas-air (not oxygen) apparatus when working single handed, and it was my contention that this might well prove to be a suitable apparatus for use by the chiropodist. More recently, Messrs. Airmed Ltd. and Messrs. Cyprane Ltd. have placed on the market even more portable forms of analgesic apparatus. These are the temperature compensated trilene-air inhalers which deliver variable percentages of trilene vapour in air, irrespective of the temperature.

What, then, are the physiological consequences of such general analgesic agents? They are :—

(1) After breathing from the facepiece for a minute or two, the patient has a greatly diminished appreciation of pain: in fact, as far as chiropodial procedures are concerned, they should feel no pain.

(2) The patient remains completely conscious.

(3) Vomiting rarely, if ever, occurs.

(4) A light carbohydrate meal can be taken before the analgesic is administered, thereby diminishing the tendency to faint in the "straight from work, starved to death," type of patient (cf tramcar and "blond" drivers).

(5) Absolutely no premedication is required.

(6) There is no "gagging" or disgust at the commencement of the inhalation, nor coughing, as occurs with certain other inhalational methods.

Contra-indications: Trilene-air analgesia is contra-indicated in the following case groups:—(1) Heart and hypertensive disease, (2) active lung disease, (3) kidney disease.

As a consequence of the above contra-indications it would be advisable for the chiropodist to obtain a certificate from the patient's physician, signifying his assent to analgesia. At first sight this seems to be a grave disadvantage, but if we take thought for a moment we will realise that the same conditions arise in the physiotherapy profession, where every patient requires a "doctor's line."

TRILENE-AIR ANALGESIA

Before discussing the chemical and physical properties of trilene it should be pointed out that the name "Trilene" is the Imperial Chemical (Pharmaceuticals) Ltd. trade name for their anaesthetic grade of trichloroethylene. Pure trichloroethylene is a colourless liquid but Trilene is coloured blue to distinguish it from chloroform. Trilene has the following composition :—

Pure trichlorethylene.
Thymol (0.01 per cent).
Waxoline blue (1 : 200,000).

The thymol is added as a stabilising agent to prevent decomposition. For the purpose of this article the words "Trilene" and trichlorethylene should be regarded as synonymous.

Preparation. Trichlorethylene is prepared by the chlorination of acetylene in the presence of antimony pentachloride. This reaction yields tetrachlorethane (acetylene tetrachloride), which is commercially known as "Westron." The "Westron" is further mixed with lime slurry, when trichlorethylene is formed. This is further purified by distillation.

Properties. Trichlorethylene is a colourless volatile liquid with a density of 1.4598. It has a sweet smell reminiscent of chloroform, but is not so sickly; it is used extensively in industry as an organic solvent. Important, though not from the point of view of analgesia, is the fact that trichlorethylene mixes freely with ether and chloroform; for storage purposes it should be kept in either metal tins or tinted bottles and stored in a cool, dark place. It is important to keep the containers away from either strong sunlight or hot surfaces, as the trichlorethylene tends partially to decompose, forming hydrochloric acid and phosgene.

Pharmacology. Whilst this is a very important subject, it must be pointed out that many of the pharmacological effects of Trilene appear only on the exhibition of Trilene in high concentrations. Mention is here made of only the more important effects.

The Lungs. Fairly high concentrations of Trilene with insufficient air or oxygen supply may lead to tachypnoea. This distressing condition is relieved by withdrawal of the drug or reduction in its

concentration; it should not occur with a midwifery-type analgesor.

Cardiovascular System:—

Blood. Trilene causes no hæmolysis of blood.

Blood pressure. Even under full anæsthesia, Trilene has little or no effect on the blood pressure; it is also thought that it may be a mild vaso-constrictor.

Heart. Scher, in his series, noticed symptoms of tachycardia and bradycardia in 23 per cent of cases. In no case did these symptoms persist longer than 15 minutes into the post-analgesic phase. Much has been written about E.C.G. changes; however, expert opinion seems to regard them as of little or no significance.

The Central Nervous System. The inhalation of Trilene in air or oxygen first results in analgesia and then in full anæsthesia. Analgesic patients often complain of sensory phenomena such as paraesthesia, stiffness of tongue and cheeks, or even that their "legs feel light." Inhalation of impure trichlorethylene or Trilene which has been used (wrongly, of course) in a closed circuit apparatus may lead to a cranial nerve palsy. This is not due to the Trilene, but to dichloroacetylene, which is believed to be formed when trichlorethylene comes into contact with hot soda lime.

Excretion. Trilene is mainly excreted in expired air, although a small quantity is excreted through the kidneys as trichloroacetic acid. Excretion after the short analgesic phase envisaged in chiropody practice would be very rapid indeed.

CONTRA-INDICATIONS Trilene-air analgesia is contra-indicated in heart, lung, and kidney diseases. Scher, in his article, advocates the use of nitrous oxide/air analgesia as safer, and local anæsthesia as safer still, in these cases.

(To be concluded)

ANKLE SPRAINS*

SPRAIN of the ankle is probably the most common traumatic lesion of the lower extremity, and occurs at all ages.

PATHOLOGY A sprain is usually defined as a partial or complete laceration of a ligament due to over-stretching. If the ligament is strong, and the force producing the injury is great, the bony attachment of the ligament may be pulled off, resulting in what is referred to as a "sprain-fracture".

Leriche has a somewhat different view of the pathology of this injury. He considers that a sprain is a local functional circulatory disturbance of traumatic origin. His classification divides these lesions into three groups: (a) simple sprains, (b) sprains complicated by laceration of ligaments, and (c) sprains complicated by avulsion of bone.

Ligaments have been shown to contain many nerve-endings. Leriche believes that a simple sprain is caused by sudden excitation of or injury to these nerve-endings, brought about by violent stretching of the involved ligaments. Afferent impulses bring about efferent sympathetic impulses. At first there is a transient vasoconstriction. This is followed by vasodilation, which causes effusion, pain, and limitation of use. The effusion further stimulates the nerve-endings, and a "vicious circle" is set up. The vaso-motor equilibrium is re-established usually in a week to ten days. Leriche believes that a "pure sprain" often exists without macroscopic ligamentous lesions, and that ligamentous lacerations and avulsion fractures are complications which unfavourably alter the prognosis, but do not necessarily influence the symptoms.

MECHANISM Most sprains of the ankle

involve injury to the external lateral ligament and are due to sudden inversion of the foot. The internal lateral ligament (deltoid ligament) of the ankle is strong and broad, and gives good support to the medial side of the ankle. The external lateral ligament, however, is weaker and less complete, and is composed of three fasciculi. Only the short posterior fasciculus is really strong, and is therefore rarely torn. Injuries of the anterior and middle fasciculi make up the majority of ankle sprains, and this article will concern itself mainly with these lesions.

SYMPTOMS AND DIAGNOSIS After a sudden violent "turning" of the ankle, there is immediate excruciating pain, which promptly abates to become a steady dull ache over the lateral side of the ankle. The patient is unable to bear full weight on the foot because of pain. Examination reveals swelling over the outer side of the ankle and frequently of the dorsum of the foot. There may be ecchymosis and muscle spasm. Tenderness is usually most marked just anterior to and below the lateral malleolus, unless there is a complicating fracture, when the tenderness is most marked over the malleolus itself.

Another useful differential test is gentle passive dorsiflexion of the foot, which is painless in the case of a simple sprain but produces pain over the site of a fracture. All injured ankles should be X-rayed because the presence or absence of a fracture obviously influences the mode of treatment.

If no fracture is seen radiologically, a further diagnostic procedure is indicated. A severe sprain may include a complete tear of the lateral ligament, and a tear of the tibiofibular ligament with a tran-

* Reprinted from the *Pakistan Medical Journal*

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sient elevation of the astragalus which has been spontaneously reduced by the time the patient is examined. This can be strongly suspected if there is excessive mobility of the foot and if the astragalus can be felt to rotate excessively between the malleoli. This test is best performed after the tender areas have been infiltrated with 10 cc. of 1 per cent procaine solution. The diagnosis can be verified by anterior-posterior X-rays with the foot forcibly inverted and everted.

TREATMENT The traditional method of treatment of an uncomplicated sprain is prompt immobilisation by means of adhesive taping ("Gibney boot"). The leg, ankle and foot are shaved, and tincture of benzoin is applied to the skin. The patient's heel is supported by the surgeon's knee, and the foot is held at a right angle to the leg by means of a bandage loop which is held by the patient. Alternate longitudinal and transverse strips of half-inch or inch wide adhesive tape are then applied, covering all except the dorsum of the foot, from the base of the toes to the upper third of the leg. An elastic bandage is then applied to keep the adhesive in place and to apply pressure to the ankle for the prevention of swelling. Crutches should be provided to keep the weight off the leg in walking. Elevation of the extremity and ice bags for the first 24 to 48 hours aid in keeping the swelling down. The taping is left on for seven to ten days, until there is no tenderness and the patient can bear full weight without pain.

Leriche's treatment of a simple sprain consists of injection of procaine (10-15 cc. of a 1 per cent solution without epinephrine) into the tender area to prevent or interrupt the "vicious circle". This provides relief of pain and the patient is allowed to use the extremity immediately without an immobilising

dressing. Pain is likely to recur after several hours, but subsides in a few more hours. A second procaine injection is given in 24 hours unless there is no pain at all.

Recently, blocking the sural nerve has been recommended for the treatment of these lesions. A needle is directed posteriorly just beyond the postero-lateral border of the tibia three inches above the malleolus, until paresthesias are felt from the needle site down the lateral aspect of the ankle and dorsum of the foot. Here seven cc. of 2 per cent procaine are injected, and a successful block is obtained within a few minutes. The patient is allowed to use the extremity immediately without immobilisation of any kind. The results are said to be good.

TREATMENT OF COMPLICATED SPRAINS Complicated tears of the ligaments and dislocation of the astragalus are treated by immobilisation in a plaster walking cast for six weeks with the foot in neutral position. An avulsion fracture of the lateral malleolus without displacement is treated in the same manner. If there is displacement of the fragment that cannot be reduced by manipulation under anaesthesia, internal fixation or excision of the fragment is advisable.

A sprain of the deltoid (internal lateral) ligament without fracture is treated in the same manner as an uncomplicated sprain of the external ligament. A fracture of the medial malleolus in perfect position can be treated by immobilisation in a plaster cast for six weeks. If there is displacement of the fragment that cannot be reduced by manipulation under anaesthesia, internal fixation is the treatment of choice. Fractures of both malleoli require careful reduction, immobilisation in a full-leg cast, and are beyond the realm of ambulatory surgery.

Trilene Analgesia in Chiropody—Part II

By T. G. Fleming, M.Ch.S., M.R.I.P.H.H

APPARATUS (1) *Scher's open method.* In this method a cotton-wool roll is split longitudinally and placed in the centre of a dental napkin. The napkin is then folded to form a square pad of approximately 2ins. sides. For adults 1.5—2.5 ml., and for children 0.5—1.00 ml., of Trilene is poured on to the pad. The napkin, held in the left hand, is then slowly approximated to the patient's face: this is done slowly to avoid the risk of laryngeal spasm due to a too-high concentration of Trilene vapour. The operator should have a slow, steady approach and speak to the patient in a reassuring manner. Once the patient is accustomed to breathing the Trilene vapour the operator's right hand should be placed over the patient's chin and the lower border of the operator's own left hand. Using this method analgesia lasts for approximately two minutes.

(2) *Continuous auto analgesia.* This method is mostly employed in dentistry and there appear to be three different types of apparatus in use, namely, those described by Hill (1944), Williams (1946) and Scher (1946). Unfortunately, space does not permit a full description but the underlying principle is simple. Trilene is vaporised by the patient's squeezing a bulb in his hand, the Trilene so vaporised being inhaled through a face-piece. With this method anaesthesia is impossible because as the analgesia deepens the patient's grip on the bulb becomes weaker.

(3) *Calvert* (1944) bubbled air through a Woolf bottle and passed the vapour through a corrugated tube to a standard face-piece.

(4) *Scher* (1947) used Trilene in an Oxford vaporiser for analgesia in mid-wifery.

(5) *The Siebe-Gorman Trilene Inhaler.* This apparatus can produce analgesia or full anaesthesia. Since all the above-mentioned models could be used to produce full anaesthesia it is doubtful whether their use could be recommended in chiropody. However, the following models have been designed specifically for the purposes of analgesia and are not capable of producing anaesthesia.

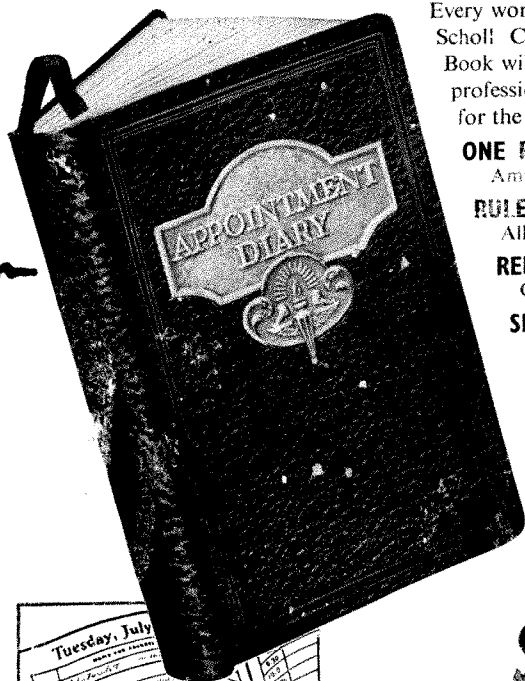
The Hayward-Butt "Trilite" Inhaler. This is a simple and effective piece of apparatus shaped something like a pen torch. The Trilene is contained in a 6 cc. ampoule, which provides analgesia for a period of between one and one-and-a-half hours. If desired a face-piece or dental nasal inhaler may be fitted.

The "Cyprane" Inhaler. This extremely portable model was designed as an analgesic apparatus; however, it can be used to induce surgical anaesthesia. The percentage of Trilene in the Trilene-air mixture can be varied at will between 0.5 per cent maximum and 0.22 per cent at the "quarter on" setting. In the "half way" setting (0.31 per cent approx.) the analgesia obtained is comparable with a 50 per cent nitrous oxide/air mixture, the result being that the operator has a fairly wide margin on either side, so that the more or less resistant case can be dealt with.

The apparatus is foolproof in design and is sturdily made. To use, the base cap is removed and 15 cc. of Trilene poured into the inhaler, the base cap is replaced and the mixture control set and

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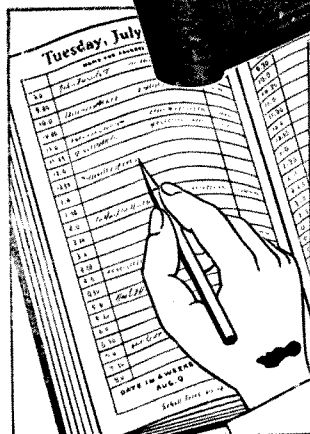
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A MAJOR REWARD From the talks now going on between the Minister of Health and the medical auxiliary bodies the profession is expecting that the basis for a State Register will emerge. We have been told that the cases of all the R.M.A. bodies will have to be considered collectively and that chiropody has no chance of being the subject of a special Act of Parliament such as that devoted to dentistry. If this position is accepted, chiropodists will have to forgo one of the most desirable and worthwhile aims which a large section of the profession has held in view for many years, and our profession will no longer be able to look forward to an expanding development towards independence.

By State Register we do not understand "National Health Service Employment Register". The time is ripe for a really national effort so far as chiropody is concerned, whatever the position of the other R.M.A. services. If a limited N.H.S. register is evolved, then all the charlatans in creation can still run around practising as "chiropodists" with as great a freedom as at present. What is needed is a State Register of Chiropodists and that only those on the register shall be entitled to call themselves or offer their services as chiropodists. This surely is the primary reward which might reasonably be expected to accrue from the talks now going on at the working party's round table. It can be considered as one of the "best rewards attainable."

CONTEMPORARY OPINION According to the Editorial of the *Chiropody Review* for November the deliberations of the M.O.H. working party are not yet complete. The Editor suggests that when the profession is stabilised "we may be presented with a structure the very tissues of which we may not have contemplated

deeply enough." He asks the J.C.C. councillors whether they have determined their attitude towards total employment by the State, i.e., nationalised chiropody, and then extends his query to the ordinary chiropodist in private practice. He exhorts members to think of these things "while there is yet time". He opines that in due course "it will not be possible to have both private and national chiropody practice," and terminates by urging the members to guide their leadership by letting them know their views on this matter, adding: "What in fact would be the vote on a motion 'That the Chiropody Profession be nationalised'?"

Whether this query is based on mere speculation or how far the nationalisation issue has been brought into the realm of possibility the Editor does not say.

OUR OPINION Our views are well known to our readers.

Firstly: We have long since stated our opinion that a "Free for All" State chiropody service is not at all likely to be inaugurated. We have given our reasons and although Britain's financial position has definitely improved in the life of the present government the Chancellor of the Exchequer has many prior calls on the national purse and would be foolish to plunge headlong into the chiropodial cauldron.

Secondly: The profession needs cleaning up.

Thirdly: If nationalisation is proposed it would be on a low price basis unacceptable to trained chiropodists.

Fourthly: We repeat our opinion that the chiropodic heaven is not to be found under the National Health Service.

Fifthly: Free development is our birth-right and we should not sell this lightly for a mess — whether of pottage or politics.

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HON. EDITOR: F. A. DREW, F.Ch.S., M.N.A.Ch.(U.S.A.) Vol. 19. No. 11. November, 1954

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WORDS TO REMEMBER At the annual general meeting of the Society of Chiropodists, held in Glasgow in September, the President of the Society, Mr. J. H. Hanby, F.Ch.S., made the following statements which we approve and endorse:—

Our reputations are in the hands of both those in official appointments and those in private practice.

It is the policy of the council to encourage by all means in their power the attainment of these standards (*i.e.*, *high educational, clinical and ethical standards*), and also to strive for the best rewards attainable.

We must also, as far as possible, should any major development of chiropodial services by the State arise, ensure that the large majority of our members who are in private practice do not suffer; rather we propose to encourage any scheme whereby patients are treated in private surgeries.

The duty of your council is to watch over the interests of our members no matter what particular phase of work they may be engaged in.

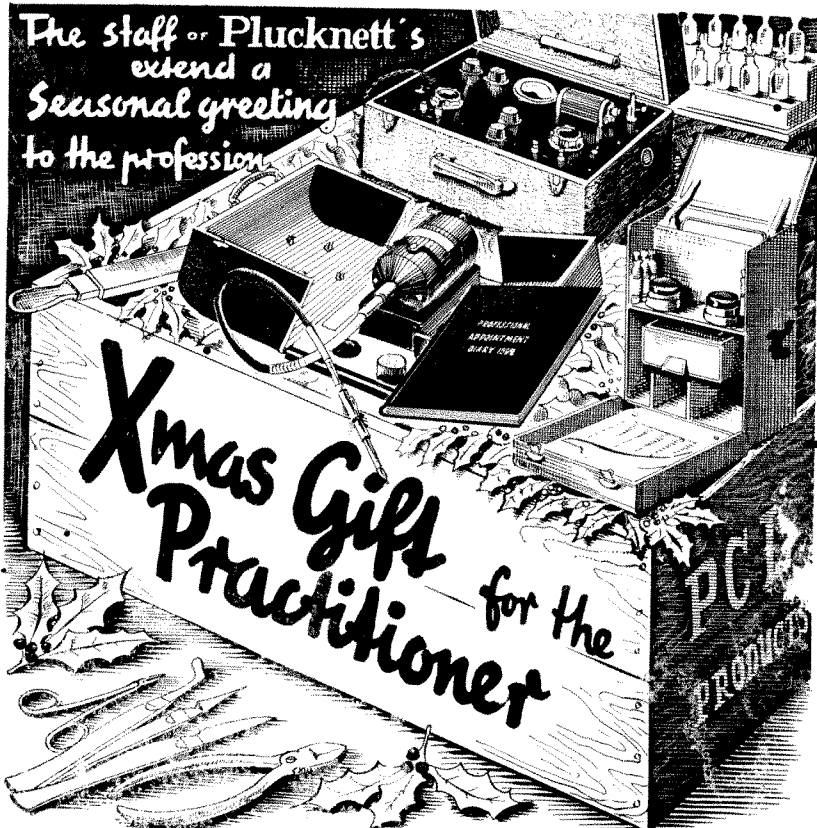
Well spoken, Mr. Hanby! These words, which fit in with our views so often expressed, must be interpreted at their full value and it is for the Society

and the Joint Council of Chiropodists to see that these principles are pushed and applied to their logical conclusion.

Mr. Hanby also indicated that in his opinion chiropodial contribution within the Health Service would be limited for many years to come. It is interesting to see that opinion is gradually and belatedly coming into line with our views so definitely expressed in our issue of March, 1949, and repeated for readers' benefit in January of this year.

With regard to the first statement above, we would remind readers that those members of the Society who are in private practice outnumber those in official appointments by about 10 to 1, whilst if we add to our figures those of the J.C.C. then the private practitioners will be found to exceed all others by about 15 to 1. Thus our reputation as a profession is pre-eminently in the hands of private practitioners who practise without supervision, with greater responsibility to the public, their own and the medical professions and acquit themselves with credit. This majority of the profession have indeed a corresponding weight of claim to consideration in all matters of chiropodial status and rewards.

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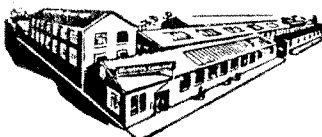
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children's shoes was to the trade a most important part of their work. He deplored mothers buying shoes too large for their children; this was almost as bad as buying them too small.

Appliance Brightens Outlook

IN AN ADDRESS to the annual convention of the Society of Chiropodists in Glasgow, Mr. Franklin Charlesworth, F.Ch.S., said that a crippled child's outlook could be brightened by fitting him with a suitable appliance.

Mr. Charlesworth demonstrated his invention of a strong, light support encasing the limbs which, in certain cases, can replace iron calipers.

Importance of Perfect Fit

WITH THE GOOD QUADS acting as foot health models at a demonstration of Foot Health Week, sponsored by the Southern Division of Gloucestershire County Council Health Committee, Mr. Alan Underwood, fitting expert of Clark's of Street, emphasised the importance of seeing that children's shoes fit perfectly.

Underwood criticised parents who send their children out without shoes or of taking them along to school shoes not measured by experts.

Thomas Needham

THOMAS NEEDHAM, of Alexandra Park, Blackburn, Lancs., died recently at the age of 84. He had practised chiropody in Blackburn for more than 60 years.

Making People Happy

A CHIROPODIST makes you happy, for, if your feet are sore, you are all tired, an elderly lady told Sir Alexander Macgregor, chairman of the Western Regional Hospital Board.

Sir Alexander told the Society of Chiropodists, in a speech at the annual convention in Glasgow, that it was, in fact, the housewife who suffered most from painful feet.

Professor Mackay, of Glasgow University, spoke of the possibility of grafting artificial blood vessels of nylon, or similar material, by which surgeons might, one day, "put joy into the tired housewives' aching feet."

Designated By Minister

CHIROPODISTs have been designated by the Minister of Housing and Local Government for the purposes of Regulations 21 and 22 of the Local Government Superannuation (Benefits) Regulations, 1954, as contributory employees or local Act contributors in the employment of a local health or education authority for the purposes of the school health service.

Foot Safety Week

NATIONAL INDUSTRIAL Foot Safety Week, organised by the Royal Society for the Prevention of Accidents, will be held from October 25 to 30. The aim of the campaign is said to be to encourage workers to wear a suitable type of footwear, because the general attitude of most workers is that only their old shoes are good enough for work.

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NOTES AND NEWS

Schemes for the Aged

A RECENT SURVEY of the feet of old people by the Middlesbrough Health Department revealed that of 310 cases, 40 per cent were urgently in need of a chiropodist's attention and fewer than 30 per cent were free from foot trouble.

The welfare services committee consequently discussed the possibility of establishing a voluntary chiropody service for the old people of the town, and the resolution was referred to the health committee.

THE CHIROPODY scheme for old people in Ramsbottom, Lanes., began on Oct. 1, following the recent decision of the Old People's Welfare Association.

The scheme is applicable to all over 60 years of age, who will be able to visit local chiropodists regularly. Half the cost of treatment will be borne by the association.

A NUMBER of old folk failed to keep chiropody appointments, it was stated at the annual meeting of Spenborough Old People's Welfare Committee, recently.

The Committee, therefore, decided to investigate the reason on the part of these old people, before asking them to make new applications for treatment.

THE FREE chiropody service for old people, started nine months ago by Dr. D. R. Snellgrove, a Luton, Bedfordshire, general practitioner, continues to expand.

Dr. Snellgrove is chairman of the Luton old people's visiting committee, who run the service.

THE OLD PEOPLE'S Welfare Chiropody Service of the Leeds Council of Social Service, among other charities, benefited from the "Miss Young Conservatives"

contest at the Central Leeds Division Young Conservatives' September Ball in the Capitol Ballroom, Meanwood, Yorks.

CHIROPODY services as a charge on the rates were recommended by the Association of Municipal Corporations in a recent report to the committee of inquiry into the problems of old age.

A FREE chiropody service is now being provided by the Audenshaw, Manchester, Lanes. old people's welfare committee.

OVER 200 old people during the last three months have taken advantage of the chiropody service run by the Newark, Notts., old people's welfare committee in conjunction with local chiropodists. This was stated at a meeting of the committee recently.

THE CHIROPODY SERVICE for old people provided by the nursing and welfare association of Mytholmre, near York, Yorks., continues to expand, according to a report recent meeting of the association.

EQUIPMENT for a new foot clinic for old-age pensioners in Wandsworth, London, has been provided by the Wandsworth Rotary Club.

Born with Perfect Feet

MOST CHILDREN were born with perfect feet, said Mr. J. Osgood, national president of the Incorporated Federation of Boot Trades' Associations, Ltd., in Belfast recently. Yet by the time they were 12, very few still had them; this was because their bones were soft and could easily be put out of shape by badly fitting shoes.

The correct choosing and fitting of

published contribution to the journal, and these were on technical subjects. In addition the A.G.M. statements made by three others were reported—hardly sufficient matter on which to judge a candidate's worth or to give even an inkling of his views.

In *The Chiropodist* of June, 1952, a correspondent suggested that the difficulties of selection might to a great extent be overcome if candidates were allowed to make a personal statement of view in the journal or in the form of a circular leaflet. The main point of the authoritative objection which this suggestion evoked was that a candidate having committed himself to a policy would be bound to maintain his viewpoint in any event, even though the case may be altered by circumstance. But as we know one of the great principles of democracy is that change of mind is not outlawed if it is justified and where major issues are involved, if conscience cannot be satisfied, resignation is always possible. It was also considered that canvassing might encourage selfish sectional interests, but equally so might blind voting. If we know nothing of a candidate's views how can we tell what interests he may have at heart?

In fact no valid objection was raised against the suggestion of allowing statements of policy to be published in a form which may reach all members. The question might, with profit, be reconsidered.

It is pertinent to wonder what other reasons may motivate the official reluctance to allow pre-election expressions of ideas and policy. Could it be, for instance, that the elected representatives fear that their policy does not enjoy the support of the bulk of the Society and realise that if put to the vote it would fail to gain approval, but that there are

other policies and views whose exponents would gain majority support?

Elected authority should always remember that in democratic society they are elected to serve the wishes of their electorate as indicated by majority opinion.

W. D. WATTS, M.Ch.S.

St. Albans.

VARICOSE ULCERS

SIR.—It was not without surprise and pleasure that I received your journal and noticed a reprint of my article on varicose ulcer therapy.

We as chiropodists are in a peculiarly fortunate position to prevent those disdressing lesions from coming into being; they are primarily the result of neglect.

A chiropodist with the most elementary training can get a case history from a patient and ascertain whether herma, hæmorrhoids or varicose veins were present in parents or other members of the family. It does not require extraordinary mental capacity to palpate the four inches or so above the medial malleolus or observe pigmentation in the area, to notice that danger signals are present.

What is needed is observation and understanding of our own weakness as two-footed animals with the predilection to weakened fascial structures and incompetent valves.

So much misery can be eliminated by properly instructing patients in self help; only through study can we elevate ourselves in the eyes of the public. No amount of advertising can do it.

Let your patient become a one-man broadcasting system; soon the din of the myriad sufferers will be heard by officials who seem to require hearing aids.

SAMUEL L. PERLMAN, A.B., Pod.D.

New York.

among those having studied a full two-year course—who can make incomes anything like that of our correspondent. If he looks at the official advertisements for chiropodists in hospitals, this alone should disillusion him.

The regimental chiropody course never pretended to turn out a qualified chiropodist; the few weeks devoted to it were quite insufficient to do anything but skim the surface, and it has no value as a chiropodial qualification in civil life. On the basis of his present training our correspondent could not obtain a post in any hospital or under any local authority. He can gratify his keen desire for medical work by sticking to the St. John Ambu-

lance Corps or the British Red Cross Society.

At the present moment the Minister of Health, in company with the two recognised chiropodial bodies, the Society of Chiropodists and the Joint Council of Chiropodists, is endeavouring to thresh out a basis of state registration, and until the results of these deliberations are made known the position of chiropody in Britain may be said to be fluid.

Once more our advice, given in all sincerity, is, "Cobbler, stick to your last"; it is paying you well and better than you can expect from chiropody while divided interests undermine progress in both directions.

LETTERS

The Editor welcomes letters on any aspect of the chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal.

VOTING SYSTEM

SIR, — Honest opinion must surely support the message of your September editorial. It is an unhealthy state when only about eleven hundred of the four thousand-odd Society members vote in the election for council. Obviously there must be a good reason for this apathy. Most of us would agree with the reason given in your editorial.

With the receipt of this year's voting papers for elections to council, we were again confronted with the curious system whereby we must vote blindly for our representatives, not knowing whether we support their views or whether we are in disagreement with them. We were asked to vote for a list of people of whom our knowledge may be confined to their name and place of work as described in the

official list which is supplied with the voting paper.

When this subject was raised in 1952 several suggestions were made as to how members could learn sufficient of the candidates to enable a vote to be conscientiously made.

It was said that the branches offered scope for learning about candidates and their viewpoints, but while some may consider branch membership to be desirable, the fact is that far from all Society members are branch members, and even if they all were, branch membership does not guarantee knowledge of all the candidates' views in regard to Society policy.

It was also suggested that a knowledge of the various candidates could be gleaned from the pages of *The Chiropodist*, but there is little ground for this assertion for it seems that prospective candidates avoid contributing to the journal on questions of policy and few write even on technical matters. In the issues of the last twelve months only three of the seventeen candidates made a

QUERIES

Answered by F.A.D.

Q Your journal is noted for its unbiased views and open approach to all matters affecting the profession, and it is because of this that I feel you are the best fitted to give me a practical and straightforward answer to my problem.

I am 35 years of age, and at present earning over £1,000 a year as a sales representative.

• In 1940, whilst serving in the Army, I qualified, with high marks, as a regimental chiropodist. This appointment I held until my release in 1946, and I possess a letter from my record office, stating that I practised as a regimental chiropodist for the whole of this period, at home and overseas.

I have been a member of the St. John Ambulance Brigade since 1938, and am still actively engaged in this work, which entails assisting at local hospitals and driving and manning an ambulance which works in conjunction with the county services.

My greatest desire is to do a job of work of a medical nature, and I have recently taken a course of chiropody by correspondence, to refresh my memory regarding theory and practice.

My intention is to start a visiting practice and later to open a surgery. I am most anxious to conform with the highest ethical standards and to charge reasonable fees.

As you will be the first to see, I am now in danger of being called a charlatan and even worse.

But please consider my position. It is quite impossible for me to take a full-time course such as is stipulated

by certain bodies; it is equally impossible for me to maintain my standard of living as an assistant for a year or so. Yet I am not unskilled, and am moved by the best possible motives and desires in this wish to enter the profession at the right level and to eventually practise full time.

Yet it would seem that I am debarred from ever becoming a member or associate of a recognised body, and maybe there are many other ex-Service chiropodists in this position. I claim no hardship, for I am making a comfortable living at my own profession, but my heart is in chiropody.

How can I gain recognition in the meantime? Are all such people as myself to be labelled charlatans and outsiders? Surely our principles and motives govern these decisions.

I cannot set up a full-time practice immediately and "on spec.", as you will appreciate, for £1,000 per annum in the first year or two from "scratch" would, I feel, be asking rather a lot.

Can you help me?—J.F.H.

A Our correspondent is obviously sincere and if he does a thing he wishes to do it properly. He appears very much in the position of the dog in the famous fable of the dog and the shadow; he is crossing a bridge and in the passing stream he sees what appears to be another dog with a larger and more desirable bone than he has in his own mouth and he is hesitating whether he will drop into the stream and get it for himself. He is in danger of finding that the bone which looked so real and so large is nothing but a shadow and disappears as he takes the plunge. Between the two he risks losing both.

My advice to our correspondent is to stick to his present good job. It is only the few among chiropodists—yes, even

There is much of an educational value and the social side in most branches has been well catered for. It is to be hoped that members will show their gratitude to the hard-worked organisers by attending the gatherings.

A BUTT OF THE PRESS

COMMERCIAL travellers, mothers-in-law and the like have for years been the subject of fun-poking by the Press and music halls. Of late, chiropodists have received their full share of fun-poking. One or two chiropodists known to me take a poor view of what they call "this indignity". They shouldn't really get so hot under the collar. For the most it is good healthy fun and sometimes very humorous indeed.

A STORM IN A TEACUP

IN THE COURSE of a lecture given at Glasgow last month, Mr. M. D. England, of the London Foot Hospital, mildly criticised the type of shoes sometimes worn by the Queen. The National Press

seized on this like a swarm of vultures, and when he gathered up his newspapers the next morning poor Mr. England found himself the subject of headlines and later of bitter editorial comment.

When he made his reference to the Queen's shoes I rather imagine Mr. England overlooked the presence of Press reporters, as it is always delicate, and sometimes dangerous, to make reference to Royalty when controversial subjects are discussed.

Mr. England's comment was perhaps a little unwise, but it certainly did not warrant the absurd fuss the Press made over it.

A QUIET PERIOD

THIS TIME of the year is usually a quiet period in chiropodial practice. It seems exceptionally so this year. My reports from all parts of the country are rather depressing. Had we finished the summer months with a really hot spell of weather, it might have been a different story to tell.



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Round and About

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MANUFACTURERS ON THEIR TOES

SOME TIME ago I commented that British manufacturers were falling behind their Continental and American counterparts, particularly in regard to the quality of latex foam. I am happy to report that a great improvement has taken place and many British products of latex foam are quite equal to the overseas products. I have handled some of these new efforts, which are really first class, at the right price, and in plentiful supply.

EX-NURSES AND THE PROFESSION

NOT SO MANY years ago it was quite common for nurses to take up the practice of chiropody if for some reason or other they gave up their nursing careers. That is not the position to-day. One seldom hears of an ex-nurse entering the chiropodial profession to-day. One nurse who did toy with the idea told me that with her earlier training and knowledge, a three-year course was rather absurd and to a certain extent a waste of time. I think I see her point.

GIVING UP PRACTICE

AN ACQUAINTANCE who has been in practice in East London for a number of years is giving up. He complains that he cannot compete with the municipal clinics where treatment can be obtained for the asking at 1s. or 1s. 6d. He calculates that two-thirds of his practice has been lost to him—or, as he puts it, has been

stolen from him. This sad story rather alarmed me, so I made further enquiries in this particular area and found that, although not quite so serious, most other private practitioners have been similarly affected.

As a profession we denounce fee-cutting commercial clinics, but ironically seem to encourage fee-cutting clinics under a municipality. Is one more of a menace than the other? I cannot see that it is.

JUST ANOTHER RUMOUR

A RUMOUR is spreading that chiropodial treatment is to be made available to the public under the National Health Service in the same way that dentistry is. I have not been able to obtain an official denial of the rumour, but in my opinion it should be ignored.

CHIROPODY IN SHOPS AND STORES

WHEN the profession is closed by means of a State Protective Register, will it be permissible to obtain chiropodial treatment in shops and stores? This highly important problem is likely to produce a clash of influential interests when the time comes to determine the issue. I think I can guess the outcome, but it would not be prudent to print it here.

ACTIVE BRANCH

I HAVE inspected the winter programmes of some of the branches of both the Society and Joint Council. They reveal plenty of activity to come.

wear trade, which are the sponsors of the Foot Health Week. Why, then, the reluctance to co-operate similarly with the trade which is so closely allied to it?

SUPPLIERS APPROVE CONVENTION

And what of the trade; how do the chiropodial suppliers feel about the idea of a collective convention and exhibition? I have tested the feelings of quite a few, most of whom give it their blessing. I am reminded that to stage a really attractive show considerable expense is involved which can only be justified by a large number of visitors. It must also be appreciated that the trade has no sectional interests and must of necessity regard every chiropodist on equal terms.

Earlier in this contribution I made mention of the Foot Health Week. This brings to my mind another reform which should be considered. I must hasten to acknowledge the splendid organisation behind this great annual event. But I

insist that it should be primarily sponsored by the chiropodial profession rather than the footwear trade. As it is, chiropodial interests play only a minor and incidental rôle. To my way of thinking this is quite topsy-turvy.

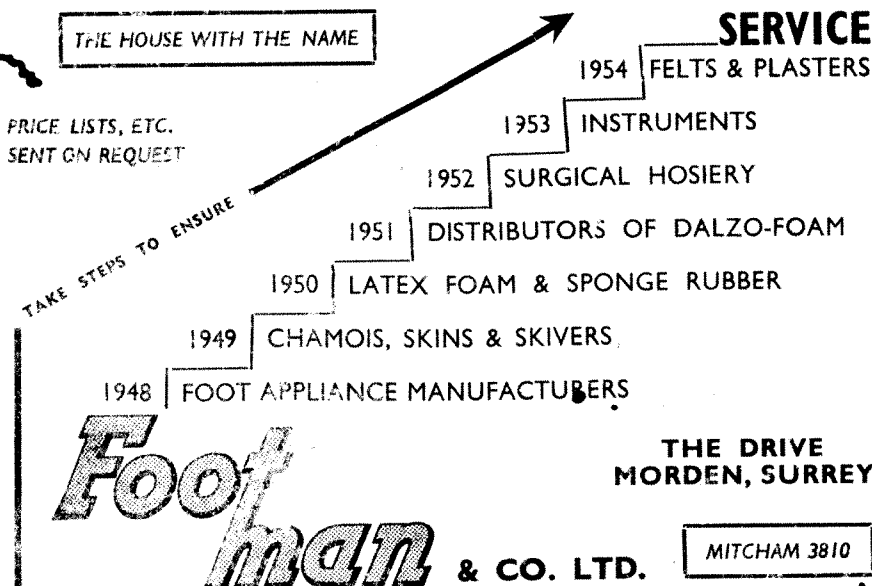
There are many other reforms which should be tackled pending the advent of protective legislation, but I will deal with these in later articles.

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TIME FOR REFORM

By G. Stanley Mercer

WE all know that the chiropodial profession is on the threshold of impending and important events and developments. It may well be that its legal protection by the State will arrive within the next year or so. That near certainty should inspire the profession to put into operation all the reforms it can and get its house properly tidied up. Officialdom, in its quiet way is watching the profession's way of conduct closely. What we do and how we do it will undoubtedly play a part when conditions and regulations are finally formulated. For that reason alone the profession should be working at top speed to put into operation as many reforms as present circumstances will permit.

SAME CONFERENCE TABLE

Periodically, representatives of both the chiropodial organisations sit at the same conference table under the jurisdiction of the Ministry of Health. This means that the bad old days of isolationism and separation are in effect over. Instead of two canoes being paddled there is only one, and even that is in danger of floundering if the occupants are careless with the paddles.

This development should have far-reaching effects and inspire the rank and file of both organisations to work more closely together and regard each other as professional colleagues and friends, rather than competitive strangers. The respective branches can do much to bring about this most desirable change. ●

I realise, of course, that any question of general agreement officially between the two organisations is a long way off, but there are many subjects and reforms

of a non-political nature affecting both which could and should be tackled. For example, the circumstances surrounding the question of conventions and trade exhibitions have considerably changed during the past few years. Fifteen or twenty years ago, when the total number of chiropodists practising was only small, it mattered little as to who sponsored these events. But to-day, with something like fifteen thousand chiropodists in practice, most of whom will undoubtedly find a place on any future State list, these great events should be sponsored by an independent authority, properly representative of the chiropodial profession and the trade which serves it.

There should be no embargo of any kind. Every established chiropodist should in his own right be eligible to participate. We should be really sensible and practical about this; it should be the job of the profession to take care of the educational part of the programme and the trade to organise the exhibition and doveltail the two in regard to sessions and finance.

CO-OPERATION FROWNED UPON

This would mean a measure of close co-operation between the profession and trade. Unfortunately such co-operation seems to be frowned upon by one or two influential members of the profession, presumably in the belief that it is inconsistent with professional dignity. Such old-fashioned and outworn ideas have no place in these modern and progressive times.

I am, however, tempted to remind my readers that the profession has displayed a willingness to co-operate with the foot-

the profession requires, and deserves, is State recognition, but such a move is up to you.

Review de Podologie (Paris)

AN ARTICLE by R. L. Cousin discusses the classification of feet according to the relative lengths of the digits. He says he has no definite statistics regarding the French population but considers that there would be very little difference from the results of the investigation made on 7,238 feet of Canadian soldiers of which 40 per cent had the first toe shorter than the second, 37 had the first longer than the second and 22 per cent had the first and second of equal length, and 1 per cent being divided into these categories. In the first group, the orders were 2=1, 3, 4, 5, and 2, 3, 4, 5, in the second group 1, 2, 3, 4, 5, and the third group, 1, 2, 3, 4, 5, whilst in the odd group he includes the square foot where there is little difference between the lengths of the first four

digits and cases where the first digit is abnormally long.

The Chiropodist (London)

In an article by M. A. Goodwin, F.R.C.S. on Conditions affecting the Metatarsal Region, the writer points out that Professor Wood Jones considers that the commonest formula of digital lengths is 2, 1, 3, 4, 5, and the second commonest, 2, 1=3, 4, 5, whilst according to D. J. Morton, the ideal foot has the formula 1=2, 3, 4, 5, and he observes: "It is now accepted by all observers that the digital formula, i.e., the relative lengths of the toes is 1, 2, 3, 4, 5 where 1 stands for the big toe. Nor has the formula anything to do with the wearing of footwear, as the formula holds in parts of the world where many people go unshod."

Reading this in conjunction with the above extract from the French journal it would appear that at least observers in Canada and France agree very much with Professor Wood Jones and not with the statement of Mr. Goodwin.

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ABSTRACTS

From Our Contemporaries

The Australasian Chiropodist

THE FOLLOWING is quoted from the *Journal*:

Firstly, may I quote an article that I read very recently, but unlike the activities of some book readers, please do not turn to the end to discover the outcome, for I assure you that it will be very surprising in many ways, so, to begin:

• "The largest portion of society, fortunately for themselves, have been brought to look upon corns in themselves as a trivial source of complaint, and so easily remedied as to be of little moment. In this country especially they are considered to be unworthy of medical skill. In the same manner, fifty years since, attention to the teeth was looked upon as a sort of unnecessary waste of time. The dentist had neither education nor skill; he was looked upon as a mere tooth-drawer who might be useful in a moment of pain. Now we can see men of the highest medical education embark in the profession...

"But a few years since a horse doctor was looked upon as an ignorant pretender..." We have now a Royal Veterinary College with professors and accomplished men belonging to it and an experienced man in that branch of knowledge is looked upon with respect and esteem. It is not improbable that before any great length of time has elapsed chiropodists will be admitted to their place in the social system; nor will hospitals and colleges disdain to receive amongst their teachers men who have studied diseases of the feet...

On the Continent the chiropodist is

esteemed as a public benefactor... Most of our courts have upon their staff of medical men some chiropodists."

After reading this, we may be tricked into believing that the words are recent ones, for such have been the topic of late conversation, but alternately, few will be really surprised to know that the quotation was from Eisenberg's "Diseases of the Feet," published in 1845, and that it appeared in a chiropody publication of 1937!

Little wonder then that the older members criticise the lack of progress, they have cause to, such discoveries are eye-openers to the younger recruits to the profession, and should prompt everyone, irrespective of their "camp" to work in unison for the advancement of their calling.

However, this has given rise to many complications, the prime one being the dictates of the body to which the individual belongs. It is hoped to overcome this by complete unison of the organisations concerned, in an effort to settle these differences from the inside. This sounds very simple, readers may be asking "Why hasn't it been done?" but instead of accepting this question, may I return it, and ask "Why haven't you helped to make it possible?" The obvious way is to give your full support to this organisation, if not in person, then let us have your views in writing—the Society is governed by the members and not as some individuals may think, that the Society governs the members.

Finally, a word on the issue which is holding up the progress of unification, i.e., the B.M.A. and their "interest" in chiropodists. Let us consider the steps necessary to attain proficiency, if we bear this in mind, why then should chiropodists accept medical registration (writes almost like restriction!), what



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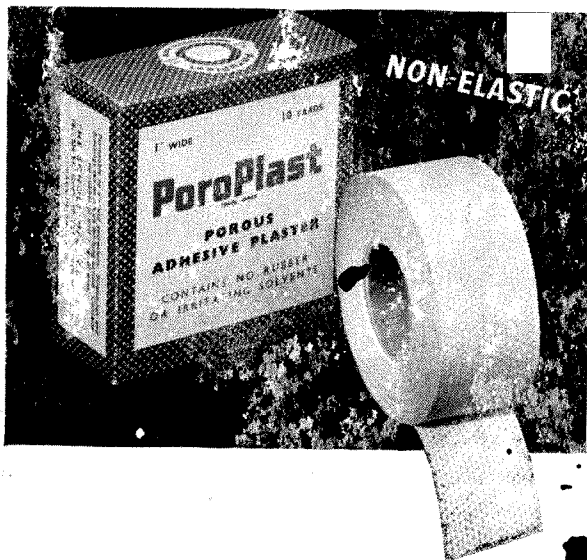
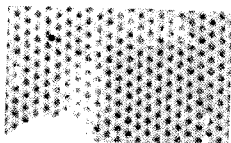
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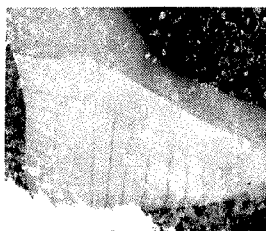
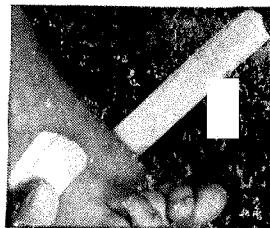
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locked; the face-piece is then attached and the inhaler is ready for use. Normally the patient holds the inhaler in the hand while pressing the face-piece over the nose and mouth. A bed-rail adaptor is also available so that the inhaler may be clamped to a chair or bed-rail, in which case the inhaler is attached to the face-piece by a corrugated tube.

The "Cyprane Tecota" Inhaler. This apparatus is specifically designed for use by midwives, although the Central Midwives' Board has not as yet sanctioned its use for the midwife working alone. Briefly the apparatus has the following main features:—

(1) The mixture delivered to the patient is consistent under all conditions.

(2) The "Tecota" is a temperature-compensated apparatus which maintains the Trilene percentage in air at a relatively constant level. In the previously described models it has been shown that a rise of 10°F. in the room temperature could result in a 30 per cent increase in the Trilene delivered to the patient. Careless use of the "Tecota," such as placing it on top of a radiator or partially blocking the air-intake grille, only results in a diminished Trilene percentage.

(3) The Trilene-air percentage is preset by the manufacturers and cannot be tampered with by the operator.

(4) Shaking the inhaler does not result in an increased Trilene-in-air percentage.

(5) The "Tecota" is set by the manufacturers at 0.5 per cent (v/v) Trilene in air at a room temperature of 70°F., with the respiratory rate of 17 per minute and a tidal volume of 500 cc.

(6) To use, the machine is simply filled with Trilene and the filler cap replaced; the face-piece is plugged in and the apparatus is ready for use.

The "Airlene" Thermo-controlled Inhaler. This model is undoubtedly the smallest, lightest and most portable tem-

perature-controlled inhaler manufactured in this country. It is produced by Air-med Ltd., of Harlow, Essex, and is a robust and reliable instrument. There are two models in production, both identical in appearance, differing only in their Trilene-air percentage calibration.

(a) *The Doctor's Model:* This model has a Trilene-in-air range of from 0.35 per cent to 1.00 per cent and is capable of producing light surgical anaesthesia as well as analgesia. The mixture control collar has three main settings, "low" (0.35 per cent), "normal" (0.50 per cent) and "high" (1.00 per cent). However, it is obvious that intermediate settings are obtainable by only partially rotating the collar.

(b) *The Low Range Model:* Here the range varies from low (0.35 per cent) to high (0.5 per cent), and the inhaler is capable of producing anaesthesia.

Either of these models may be strapped to the patient's wrist or clamped to the bed or chair rail and connected to the face-piece by means of a corrugated tube. The "Airlene" inhaler accurately administers Trilene-air mixtures over a range of room temperatures between 13°C. and 35°C. (55°F. and 95°F.) by means of a bimetallic helical-wound thermo-control unit. To use, the base is unscrewed and Trilene (20–60 cc.) is poured into the lower chamber, which is packed with absorbent elements. Any excess of Trilene then drains away through the holes forming the primary air inlets.

According to the manufacturers, serious external damage to the inhaler has no effect on the accuracy or functioning of the temperature compensating mechanism.

ADMINISTRATION The fact that there is no cumbersome ritual to be observed in the administration of Trilene analgesia should not blind us to the desirability of

taking a few elementary precautions, the practice of which should render the analgesic session pleasant to both operator and patient. These precautions are :—

(1) The patient should be instructed to empty the bladder before the session begins.

(2) All dentures should be removed.

(3) The chiropodist should have all his materials ready.

(4) A third party, preferably a woman, should be present.

(5) The patient should be comfortably seated.

(6) Patients must be assured that they will not lose consciousness and that if they use the apparatus properly they should feel no pain.

SUMMARY The problem of "pain whilst operating" is examined with reference to the chiropody profession. The various analgesic drugs at our disposal were then briefly reviewed and found unsuitable except as post-operative dressings. The criteria of an operating analgesic was then postulated and other methods of producing analgesia were examined. It was suggested that general analgesia might be the answer to the problem, consequently Trilene-air analgesic methods were studied at length.

CONCLUSION Bearing in mind the "set up" of the chiropody profession, general analgesia appears to be the reasonable answer to our problem of pain. Not only is pain relieved, but in many cases the tension and fear associated with painful procedures is eliminated. There is in a number of cases a marked amnesic effect, the patients afterwards forgetting about their visit to the surgery. Using the inhalers which only produce analgesia, the chiropodist has at his disposal an instrument capable of banishing the spectre of pain which has for so long haunted the most elementary of surgical procedures.

With such low Trilene concentrations there is no risk of the patient becoming anaesthetised, or of developing symptoms of some of the sequelae occasionally found in full Trilene anaesthesia. Having thus eliminated pain, the chiropodist can then concentrate on those operative procedures which, owing to the painful reaction they invoke, were formerly considered to be but theoretical possibilities.

The question now arises, should Trilene analgesia be practised in a promiscuous fashion by anyone who can afford the apparatus? The answer is, of course, definitely not. Before any chiropodist considers launching into practical analgesics he should have studied the subject thoroughly and be acquainted with the workings of the particular form of apparatus he intends to use in his surgery.

As the technique develops and gains ground, the chiropodial organisations will have to consider adding "general analgesia" to the steadily mounting list of subjects on their curriculum. In the meantime, further work must be done to "sew up" the subject for presentation to the chiropody practitioner.

This article has been written with the hope that chiropodists will seriously consider the need for such a technique in the profession. Only too often we hear of and meet patients who say that previous chiropodists have put them through great pain in attempting to relieve them of some painful condition.

For the convenience of those who would like to know more about the subject a bibliography is appended. Of the books and articles mentioned therein I would particularly like to draw the reader's attention to the article by Dr. Scher published in the *Dental Record*, September, 1946. Anyone who would go further in the matter of Trilene analgesia is strongly recommended to read it, as it contains observations on side effects, etc.,

which have not as yet appeared in the text books.

Acknowledgments

Thanks are due to the undernoted firms for letting me have details of their equipment, etc.:—

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The Role of the Chiropodist in Diabetes

By Anthony Sindoni, Jr., M.D.*

THE person with diabetes to-day is not receiving the same therapy as did the diabetic in the pre-insulin era, or the one during the plain insulin period, i.e., the interval prior to the discovery and use of the delayed or slow acting insulins—protamine zinc, globin insulin with zinc, or the N.P.H.

Fortunately, to-day, the condition diabetes is apparently well controlled. The patient is able to live and enjoy life as any other person. Great accomplishments have been achieved by them in the advancement of science, politics and economics throughout the world.

But the most important question asked by the individual with diabetes is: "am I safe from the complications or associated peripheral arterio-vascular conditions of diabetes?"

The question can not be absolutely answered. We realise, however, that the person with diabetes can now extend his life span, even approaching that of a normal individual, a situation which has been made possible through insulins, diet, antibiotics and other medical advances.

These have enabled the diabetic to eat a normal or adequately balanced diet, not a diabetic one, as in the pre-insulin era, restricted in all the essential vitamins.

But in spite of insulin and newer knowledge of nutrition, vascular complications, or associated disorders are increasing, with resultant invalidism and heightened mortality rate. Numerous advancements have been made, however, to reduce vascular incidence and mortality rate, and many more are in the experimental stage.

Some of these are: first, the advocating of a normal, adequate diet of a high protein, carbohydrate and low fat.

Second: the introduction of the slow acting insulins—protamine zinc, globin with zinc and N.P.H., as a result of which the patient has been more co-operative and the carbohydrate metabolism apparently better controlled.

Third: the improvement in the diagnosis and treatment of peripheral vascular disease.

Because peripheral arterio-vascular disease, or associated vascular disorders, have contributed much to increase invalidism, as well as the mortality rate,

* Paper read before the Medical Society of Delaware, Rehoboth, U.S.A.

in spite of the newer advances, they are of much concern to all physicians.

The true aetiology of peripheral arterial vascular disease in diabetes is unknown. Whatever relationship exists between control of the diabetes and incidence of peripheral arterio-vascular disease is still a debatable issue. We are aware, however, that adequate control of diabetes does not mean simply aainment of a normal blood sugar level. It means the attainment of an apparent normal carbohydrate metabolism for the patient who is upon a balanced or optimum diet, with or without the aid of insulin, as evidenced by the normal blood sugar level.

- Since the patient's diabetes is adequately controlled measures must be taken to help prevent disorders of the lower extremities. The earliest signs of arterial vascular disease are usually present in the feet. This area is the most neglected part of one's anatomy.

Little does one realise that peripheral arteriovascular disease is 12-15 per cent more prevalent in diabetics than in non-diabetics.

Since the person with diabetes to-day is becoming more conscious of disease of the lower extremities, especially of the feet, he is more aware of the advice and care of the chiropodists. The trained chiropodist who detects circulatory disturbances in the lower extremities, or infection of the feet in the course of routine care, is in a vital position to help advise patients to seek the aid of his family physician.

When any slight abrasion or discolouration of the feet is observed the physician's advice is immediately sought. The patient is taught to follow certain precautionary rules as to general care of his feet or lower extremities. He must not wear tight garters or shoes, must avoid such strong antiseptics as iodine, as well as hot water bottles, and rusty razor

blades. He should be instructed to cut toe-nails straight across, soak feet in a basin of warm, soapy water, then, rinse the feet thoroughly with water. In drying the feet, the patient is advised to use a soft towel and to sponge, not rub, between the toes. After the feet are dry, he should gently massage with lanolin or olive oil. Finally, the patient should be taught general foot exercises or the Buerger-Allen exercises to help improve the circulation of the lower extremities.

Chiropodists to-day, must take their place among those doctors who will help discover the existence of diabetes, as well as help to prevent vascular disorders of the lower extremities in the diabetic.

In our own metabolic department, where we have over 800 registered diabetics coming to our clinic at regular monthly intervals, we have observed a noticeable reduction in the number of amputations, in spite of the increasing incidence of peripheral vascular disease, since the establishment of the chiropodial department twenty years ago. This I believe is a direct result of the fact that we subject patients to periodic examinations of their feet.

The value of the chiropodist department is evident in the various outstanding clinics throughout the country, in the New England Deaconess Hospital, Mayo Clinic, Mt. Sinai Hospital, New York Emergency Hospital, Georgetown University Hospital, Washington, D.C., Grave-New Haven Community Hospital, New Haven, Connecticut, Cedars of Lebanon Hospital, Los Angeles, and in numerous other institutions.

To-day the sacrifice is too great to help combat the increasing prevalence of peripheral vascular disease in diabetes.

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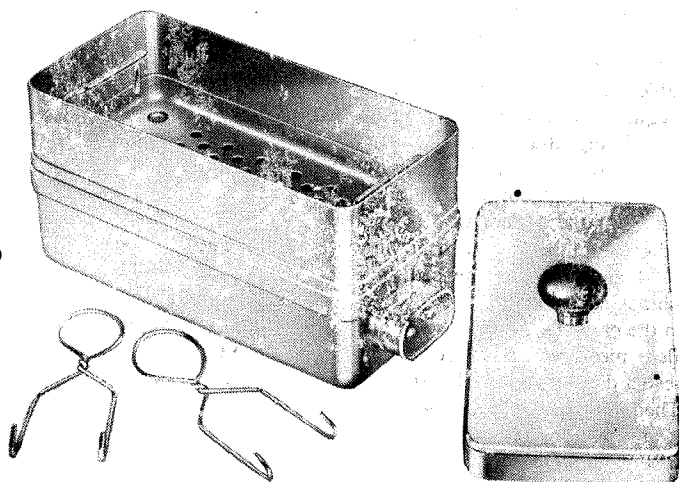
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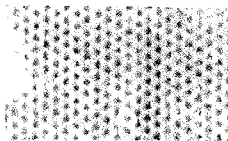
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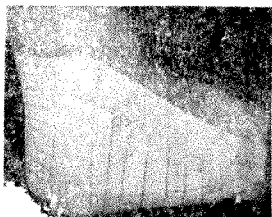
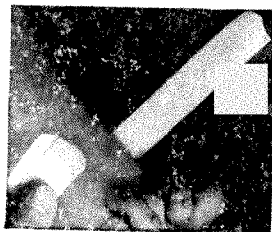
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ROOTS OF APATHY

By G. Stanley Mercer

THE apathy which has overtaken the rank and file of the profession in recent years has become the subject of considerable controversy. Articles and letters in the chiropodial Press indicate how serious this has become.

Apathy is a common complaint in all fields of organised life, but seldom have I seen it so acute as in the chiropodial profession.

I have been trying to probe the causes underlying this somewhat unhappy state of affairs. Accordingly I have questioned a number of chiropodial acquaintances and quote below a few of the explanations given to me. The first said:

I have a busy practice and have no time to interest myself in policy making. I pay my dues each year and am content to leave the future of our profession in the capable hands of those elected to safeguard our interests. For me it is a simple matter of faith and trust in our leaders.

I certainly admire the loyal spirit of this acquaintance, but is it quite fair to leave it all to his leaders? If things had been moving smoothly in the right direction I would agree with every word he said. But things have not been moving either smoothly or in the right direction.

Everyone seems to agree that the profession has for years dragged along in a condition of chaos. A pooling of the best brains has been a need manifest for years. How on earth can the brains of the profession be collected together if no one outside the narrow confines of the leaders displays any interest? Moreover, I suggest that this acquaintance is a little selfish in expecting others to give up their time in his interests, which they

too can perhaps ill afford.

The next acquaintance I questioned said:

Of course I am filled with apathy. How can you expect otherwise? I live in a remote area, therefore through no fault of my own I am out of touch. The medium of my official journal is the only means I have of information, and it gives next to no information. I know that our profession is the subject of official interest, but other than that inadequate knowledge everything is shrouded in mystery. I can't very well enthuse over something I know so little about. Give us proper progress reports from time to time and there will be less apathy.

In my view that last sentence hits the nail squarely on the head, and represents the feeling of a countless number of practitioners. Those charged with direction must expect to give proper and adequate accounts of their stewardship at reasonably frequent intervals.

My next acquaintance had this to say:

Years ago, before my organisation merged with the Society, I not only attended but looked forward to every branch and general meeting. I was made to feel that I was somebody and that my views and opinions were at least respected. I was given the fullest opportunity to express them. Not so to-day. If I attempt to voice an opposing view I come to be regarded as an agitator or rebel, and sooner than have such a label fastened to me I hold my tongue and remain—apathetic. I can appreciate this viewpoint, even if it suggests weakness. It is quite natural

to some folk to avoid unpopularity and the quickest route to that is to become an agitator or rebel.

The last acquaintance I questioned sought an easy way out. He said :

I admit to taking no part in matters of controversial chiropodial policy, but I resent being called apathetic. Who am I to sit as an armchair critic on the work of others? If people are appointed to manage let them get on with the job without being pushed around by folk who have no inside knowledge of our difficulties.

How very self-satisfying! All the same, I regard this explanation as the essence of 100 per cent apathy. I have an equal dislike of armchair critics, but I hold a great admiration for a constructive critic. I would also remind my friend that successful management of any kind is more often than not dependent

upon the manager's willingness not only to accept constructive advice — or criticism — but invite it.

I reminded each of those I questioned that when members of the Society were called upon to elect new councillors only about 25 per cent of them recorded their votes. I agreed with their explanation that this poor response might not have been due to apathy but more because they knew next to nothing about the people they were asked to vote for.

Finally, the rank and file will do well to understand and appreciate the danger of their continued apathy. The profession's major problems are drawing near to their solution. It would be wrong to assume that the path ahead will be smooth and strewn with sweet-scented roses. If, instead of the roses, only the thorns remain, the indifferent attitude of the rank and file must assume its fair share of the responsibility.

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by "Vigilant"



MR. EDWARD D. GLOVER

IT IS WITH sorrow I report the passing of Mr. E. D. Glover, a founder of the Joint Council of Chiropodists. I cannot claim the privilege of having known Mr. Glover well, but I did meet him on a few occasions. However, each time he impressed me by an obvious sincerity. Beneath his quiet manner one could detect courage and a firm belief in his convictions. Mr. Glover will be mourned by those who worked so closely with him.

SOCIETY COUNCIL NEWCOMERS

MR. H. B. FORD, MR. H. ROSENSTEIN and MR. G. B. ROYFÉ were the three newcomers elected to the Council of the Society. I wish them well and a successful term of service.

I STICK MY CHIN OUT

I CERTAINLY stuck my chin out, and got it bruised, when last month I commented that fee-cutting commercial clinics are no more of a menace than fee-cutting clinics under some municipalities. In the course of a long letter, one reader angrily states that one is honourable whilst the other is dishonourable.

My comment was not prompted by any question of honour or otherwise. My point was that both have exactly the same effect on private practice. For ex-

ample, a patient of comfortable means has been in the habit of receiving treatment from a private practitioner and paying the normal fee. Then suddenly she discovers that she can obtain efficient treatment at the municipal clinic at a cost of 1s. or 1s. 6d. and takes advantage of it. So far as the private practitioner is concerned, the municipal clinic has therefore become a menace, surely. And ironically enough, the private practitioner has himself contributed by way of his rates to making this municipal fee-cutting possible.

I am every bit in favour of municipal clinics, provided their activities are confined to old-age pensioners and that class of the community who genuinely cannot afford the services of a private practitioner.

On this same subject another reader is forthright in his comment. He says: "We have only ourselves to blame. As a profession we have almost begged the municipalities to establish these clinics. In other words, we drew the razor across our own throats. Let's not squirm now."

A HEALTHY SIGN

IT IS ENCOURAGING to observe the development of a better spirit between practitioners of the Society and Joint Council. The tendency to snub each other is fast disappearing. Members of both groups seem to understand that whatever sweets are in the bag will have to be shared equally. It seems only yesterday that it was rare to find mem-

bers of opposite groups mixing together, even socially. Now it is something commonly pleasant. And I trust I shall not be considered immodest when I suggest that this journal—and this column in particular—has had a little to do with this happier turn of events.

PATCHY

THERE ARE a good many vacant spaces in appointment diaries just now. Most chiropodists report a quiet period. Most people economise at this time of the year to enable them to let loose a little for Christmas—and when the economy bug is at work, the poor old chiropodist is among the first to be bitten by it.

DELIBERATIONS CONCLUDED

THE DELIBERATIONS of the Working Party of medical auxiliaries sponsored by the Ministry of Health have concluded. I understand that a report will soon be published. According to the little information available the two chiropodial

organisations represented on the Working Party have worked well together and reached agreement in regard to the major issues. That is how it should be, and indeed should have been many years ago. When the recommendations agreed upon are revealed to the profession we shall be in a position to assess the value of the work done.

HEARD ON THE TRAIN

I FELT REALLY angry when the other evening on the train I overheard the following conversation between two passengers:

"My feet are killing me. The doctor has recommended ——'s corn cure."

"That's no good. Why not try cutting them yourself—with a nice sharp razor blade?"

Neither the doctor nor the passengers had ever heard of a chiropodist, I suppose.

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CASE NOTES

An elderly female patient complained of pain in the extremity of the great toe, and thought it was the nail but she was not sure whether from the sides or the middle.

The first phalanx of great toe was much adducted, and overlapped the second digit. The nail was of normal thickness and texture but very arched; in fact a "shoe-moulded" toe, altogether.

Examination disclosed no obviously opaque point or patch in nail and there was no callous formation in the grooves, neither was the nail ingrown, yet the patient said she had had two months of great discomfort and sometimes crippling pain.

Close examination showed a suspicion of localised redness under the nail at a point one-third from the distal end, and this would be the point which would contact the shoe toe-box in view of the overlapping digits. Palpation with a probe tip indicated this point as the source of maximum pain and that tension must be relieved at this point, plus protection from shoe.

For treatment, a hole was drilled carefully through the nail at the point indicated, about $\frac{1}{16}$ in. in diameter, and beneath this was found a subungual heloma which was inflamed and and very fibrous in formation. This was enucleated with some difficulty through the aperture made and afterwards the cavity and whole nail area were dressed with acriflavine emulsion, protective padding applied, and the toe enveloped in tubegauze. Relief was considerable. At the next visit the toe was cleaned up, the cavity cleared, and a 20 per cent salicylic ointment applied, padded, and patient instructed to return in four days.

At the third visit the whitened tissue

caused by the ointment was removed, nail trimmed and cleared generally, a dressing of tulle gras applied under and over the nail, covered by tubegauze; a removable pad was supplied and the patient requested to return if the lesion should give any trouble, and in any case to return in two months' time.

A warning was given to wear shoes with deeper toe boxes and to guard strictly against sharp heels.

To this account it must be added that the same patient had been some years previously with ingrown nail trouble, from which she had apparently had no recurrence. At that time she was a court shoe wearer, wearing no other kind of footwear, and was persuaded to adopt a "pump" type. Perhaps the change was abandoned when the trouble was past, for such is human nature; at any rate she was not wearing a court shoe on this occasion but was evidently still more concerned with smartness than comfort.

People will certainly endure pain for the satisfaction of feeling smart and well dressed. One must applaud their self-respect even if one laments the dire results which attend their mistaken foot habits.

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ABSTRACTS

From Our Contemporaries

Chiroprody Review (London)

At the present time males in Great Britain between the ages of 65 and 70 number about 888,000, of whom approximately 350,000 (40 per cent) continue in either whole-time or part-time employment. —70 per cent at age 65 falling to 28 per cent at age 69. About 20 per cent are incapable of work on account of chronic disabilities, there thus remaining about 400,000 who could or should be actively contributing to the national economy in whole or part-time employment. The number of males over the age of 70 is approximately one and a third millions, rather less than 13 per cent of whom are occupied in gainful industries or other services.

Canadian Chiroprody Journal

Dr. A. Darwin Corley writes :

I am sure that most chiroprodists become discouraged when they realise that there are no preparations available that will show satisfactory results in the treatment of severe mycotic, onychogryphosis type nails. At two lectures on dermatology this year, Drs. Sutton and Foerster, both M.D.'s, stated that we are still hunting but do not have the answer. However, here is a technique we have been using for the past six months with results better than any previously used.

First—Reduce the nails by burring and trimming as much as possible.

Second—Have the patient buy a flat toothbrush with plenty of bristles (preferably nylon).

Third—Have them scrub each nail separately, using 2 per cent hexachlorophene soap, daily.

We dispense both toothbrush and soap • and check them bi-monthly. The tooth-

brush, being small, makes them brush each toe separately and the soap leaves a film of surgical sterility about the skin and nails. We use a liquid or bar soap designed for surgical scrub-up preparation.

The patients like this because it gives them something to do at home and lets them take part in the treatment.

Australasian Chiroprodist

Many forms of treatment have been used for plantar warts. Probably the most important thing is for the person dealing with the lesion to use an agent which is known to be effective and with which he or she is familiar. Whatever treatment is used there will always be a proportion of cases which prove difficult either because they are slow to respond to treatment or because they grow again after appearing to disappear. The following are some of the more commonly used therapeutic measures :

(1) *X-ray therapy.* This is painless, easy and effective, but calls for specialised equipment and training which limit its general use. The wart is well pared, a lead shield is placed around it to protect the normal skin and then it is irradiated. There may be some increase in tenderness a few days later, but usually all soreness disappears after about 10 days. It may be 6 to 8 weeks before the wart disappears.

Mosaic warts are not radio-sensitive and hence are not treated by this means. It can also be said that, by and large, the younger the patient the more effective the treatment is likely to be.

(2) *Freezing with carbon dioxide snow* causes some discomfort at the time of application, a disadvantage when treating children. With a pencil of snow firm pressure is applied for 3 to 5 minutes, which produces a blister around the wart. After a few days the roof of the blister with wart attached is cut out with a pair

of sharp curved scissors. Even if the wart does not come away cleanly it often has been damaged to such an extent that it will shrivel up and disappear.

(5) *Diathermy and cautery under local anaesthesia.* These methods have a place in treatment but they should be reserved for recurrent cases. This method also has the disadvantage of causing some discomfort when the anaesthetic is being injected.

(4) *Excision.* This method should also be reserved for recurrent cases. Skin grafting may be necessary on some occasions.

(5) *Keratolytics.* The use of salicylic acid in various forms is a useful adjunct to treatment. In some cases warts may be completely cured by this means but it has the disadvantage of being slow. However, it can be a valuable aid, especially for some of the widespread mosaic warts.

(6) *Corrosives.* The author's experience with these chemicals is limited to the occasional use of podophyllin, but there is no doubt that many of them have given excellent results. These applications may cause some pain but are efficient.

(7) *Formalin.* The use of an aqueous solution of formalin is time consuming but is often a very effective remedy. A 3 per cent solution has been advocated but there is no reason why stronger solutions should not be used. One method is to get the patient to soak the wart for half-an-hour twice daily in a small receptacle containing the lotion, a shallow ash-tray being an example of the sort of container that is suitable. Protective Vaseline is smeared on the normal skin around the wart. The wart tissue becomes hard and is easily broken away but the treatment may take several weeks. It is especially suitable for mosaic warts.

(8) *Injection of local anaesthesia.* A recently introduced method of treatment is simply to inject the wart with local

anaesthetic and do nothing more. It is too early yet to assess whether this is effective, as the method has not been in use for very long.

Journal of N.A.Ch. (U.S.A.)

Two items which can be used effectively for sterilisation of instruments have recently been introduced. One is a cellulose sheath, in 40-foot lengths, which is telescoped on itself so that each stick is nine inches long. Instruments are inserted into the sheath, which will completely cover them. Sheaths may be cut to proper lengths and the ends can be twisted to give complete enclosure when placed in a steriliser or autoclave. When sterilisation is completed, the instrument remains in the sheath until ready for use. Single instruments may be removed without touching others in the enclosed package.

FROM an article by Dr. Milton E. Ashur on the Treatment of Ankle Sprain.

In the treatment of 50 patients with ankle sprain, all of whom were salesmen driving automobiles or trucks and 50 of whom were under workmen's compensation, so that it was felt necessary to keep them working, the following procedure was used:

1. A careful history of just how the sprain occurred and how long of time since the injury.

2. The treatment applied by either the patient or someone else.

3. Roentgen study (to rule out fracture or dislocation), with immediate development and reading of the film.

4. Palpation of the area to determine the area of maximum pain.

5. Application of a suitable antiseptic to the skin.

6. From 3 to 5 cc. of procaine, with 1:100,000 epinephrine and about 15 TRU Wydase^(R) is injected slowly. A long, thin 25-gauge needle is used.

7. A simple ankle strap is applied which will permit the foot to extend or flex. This is done more for the psychological effect than from actual physical necessity. Re-injection rarely is required.

With procaine alone we had noticed, in a few cases, as a side effect, an increase in pain for a few minutes about one hour after injection. This was caused by an increase in the blood supply to the procaine-infiltrated tissues. The pain disappeared in fifteen to twenty minutes. Others have also noted the same phenomenon. When Wydase is added to the procaine this side effect does not occur, probably because less anaesthesia is used.

It is important to emphasise that in treating athletes during vigorous activity, such as in football, baseball, basketball and soccer games, it is not wise to administer the injection and permit the player to return to the game immediately.

BOOK REVIEWS

TEXTBOOK OF CHIROPODY, by Margaret J. McKenzie Swanson, B.Litt., F.Ch.S. Second Edition, 268 pp., 182 illustrations. Published by E. and S. Livingstone Ltd., Edinburgh and London. Price 22s. 6d. nett; home postage, 7d.

THIS well-presented and well-illustrated book is evidently written primarily for students of chiropody in training. It is impossible to confine the study of chiropody to 268 octavo pages; each branch of the study requires to be dealt with in far greater detail than can be accomplished in a small book of this kind. The fact that a second edition is called for shows that the first edition achieved success; we feel that in this second edition we should have liked to see much more about the various alternative methods of treatment of common

lesions of the foot, modern materials, and more about alternative methods of padding and strapping, which would give the book a wider field of interest. However, its value to the student in training is considerable, as it provides an introduction to the fundamentals of chiropody and serves as a jumping-off ground to the study of more voluminous and specialised treatises. The majority of the illustrations, which are impressive, are photographic reproductions, with a sprinkling of line drawings. We wish for this textbook the success it deserves in its particular field.

ELEMENTS OF PHYSICS, by A. C. Pawson, B.Sc. (Leeds), B.Sc. (London). 189 pp. Published by The Actinic Press, London. 10s. 6d. nett.

THIS book is one of the best of its kind we have encountered. The author sets out to give the student a grounding in the elements of physics sufficient to enable him to pursue his professional studies with intelligent understanding. There can be few branches of scientific study where a knowledge of physics is not essential, and certainly the chiropodist will find this book of great interest, perhaps particularly as regards the chapters on matter and motion. Other sections deal with matter in relation to light, heat, vibration, molecular motion, magnetism and electricity, and one can say that any chiropodist should have covered most of the field dealt with by the author before pursuing specialised physio-therapeutic studies. This book supplies a groundwork to be built upon and at the same time those whose schooldays date into the distant past will find herein an interesting and pleasant means of renewing acquaintance with the various subjects. This should prove a successful publication and is good value at 10s. 6d.

NOTES AND NEWS

Ayrshire Appointments

MR. JAMES ANDERSON, of Prestwick, was appointed the first chairman at the inaugural meeting of the new Ayrshire Branch of the Society of Chiropodists at Prestwick, Ayrshire, Scotland, recently.

Miss I. G. Wills, of Ayr, was appointed secretary; Mrs. A. P. Innes, of Prestwick, treasurer, and other members of this first committee are Mr. M. Jack, of Ayr, and Mr. M. Cruise, of Newmilns.

There was a representative attendance of members from all over the county.

Foot Care Hints

HINTS on the care of the feet were given recently by Mr. W. Roberts, a Southport chiropodist, to the Arts and Crafts section of Ainsdale Townswomen's Guild.

Mr. Roberts was the speaker at their meeting in the Congregational Hall, Ainsdale, Lancs.

Permission to Contribute

APPLICATION for permission to contribute £150 towards the chiropody service provided by the British Red Cross Society now operating in the Kintyre, Cowal and Lorn areas, Argyllshire, Scotland, which it was hoped to extend to other areas, was made by the County Council to the Secretary of State recently.

Too Many Flat Feet

TOO MANY CHILDREN in Nelson and Colne have flat feet, Dr. Bowman, Schools Medical Officer, Colne, Lancs., recently told members of the Divisional Education Executive.

Dr. Bowman recommended the wearing of strong shoes with heels, saying that these afforded greater support and

support to the feet than rubber plimsolls. The wearing of bedroom slippers about the house should be discouraged, he added.

Surgery in Cottage

THE ESTABLISHMENT of a chiropodist's surgery in a cottage in the High Street, Baldock, Herts., was recently approved by the Baldock Urban District Council.

The cottage, vacant for some years, was previously used as political headquarters.

Plaster Cast Instruction

THE BLACKPOOL and Lyde branch of the Society of Chiropodists recently held their 67th meeting at the surgery of one of the members in Coronation Street, Blackpool, Lancs.

The lecturer, Mr. E. Fray, gave instruction on the making of plaster casts.

Footwear Education

THE NEED for education on correct footwear was stressed recently by Dr. T. H. Parkman, Borough Medical Officer of Health, Hastings, Sussex, in his annual report. He claimed that choice of suitable footwear for every occasion would obviate complaints of discomfort so frequently heard.

Schemes for the Aged

A SCHEME to raise funds to provide a chiropody service for the old people of Hampshire is being considered by the Personal Service Committee, established by the Hampshire Council of Social Service.

PROPOSALS for the provision of a chiropody service for old people, under the National Health Service (Scotland) Act, 1947, by the County Council, Hamil-

ton, Scotland, was recently approved by the Secretary of State.

It was proposed to provide the services of a qualified chiropodist for elderly people whom doctors certified to be in need of such treatment, at the County health institutes, but domiciliary treatment might be made available where necessary. Charges to be made for treatment would be determined later.

Authority to contribute to any voluntary organisation, and to include amongst its objects the provision of chiropody services, was granted to the Council.

A NEW SERVICE for old-age pensioners of Fareham was recently organised by the Fareham Division of the Red Cross, Fareham, West Sussex.

A charge of 2s. 6d. will be made for treatment.

CHIROPODY TREATMENT at a reduced rate has been provided for the old-age pensioners of Hayes and Harlington, Middlesex, by the Old People's Welfare Committee.

Charges for treatment, available every other Tuesday, will be 1s. 6d. per foot or 2s. 6d. for both feet.

Chiropody should be included in the National Health Service was the view recently expressed by the Sutton Coldfield, Warwickshire, Old People's Welfare Committee. The committee propose to demand its inclusion on the principle that the feet are just as important as the teeth.

FINANCIAL assistance towards the foot clinic of the Willesden Old Folk's Association, Willesden, Middlesex, was recently refused by the Middlesex County Council.

The service, which was started in 1952, has given free treatment to 200 old people.

THE SETTING-UP of a chiropody service for old people was among the improvements which might result from a saving of as little as 10 per cent of the £43,000,000 spent annually on drugs, Mr. Iain McLeod, Minister of Health, said at Southport, Lanes., recently.

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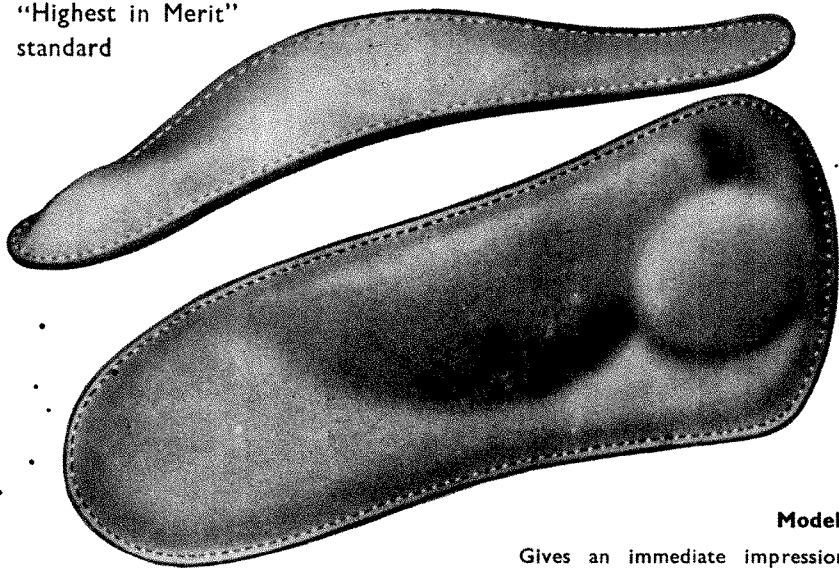
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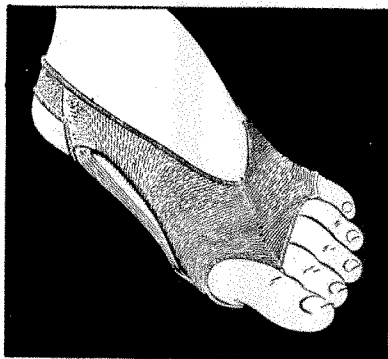
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LOOKING BACK As 1954 draws to a close we find the position of chiropody still shrouded in a mist of doubt. As December arrives each year we feel impelled to look back along our tracks to view in perspective the outstanding events of the year, if any. The outstanding event of the past twelve months can hardly be said to have been engineered by the profession itself, but rather to have been brought about on the initiative of the Minister of Health. This event surely was the bringing into mutual consultation of the Society of Chiropodists and the Joint Council of Chiropodists as the result of the formation of the M.O.H. working party which sent them all into a huddle from which they have not yet fully emerged, and without which these two bodies might have continued to travel miles apart in aims, aspirations and policy generally. Now they are obliged to bring their policies into line, modified no doubt by the dictates of the M.O.H.

In a past issue we have set forth side by side the course pursued by both the above mentioned organisations and there is little doubt in our mind that when these two policies are put through the M.O.H. mincing machine the resultant commodity which will be served up to

the rank and file chiropodists for their consumption will be coloured more by the bread of the larger organisation than it will by the red meat of the smaller body, and will be flavoured by the mixed herbs of the various R.M.A. bodies and jacketed by a composite

council.

In other words, it appears to us evident that someone has to give way a lot on their declared aims and ambitions and it appears probable that the J.C.C. will be the greater sufferer in this respect. Nevertheless, they can claim to have been always forthright for the independence of the profession, and if their ideas have proved impossible of realisation because of the intractability of their

To all our readers at home and overseas we send our greetings and sincere wishes for a happy and peaceful Christmas and good health and prosperity in the New Year.

opponents, they can always feel that they fought for chiropodial freedom with a vehemence beyond their effective capacity. Had the Society been as keen on a policy for the profession similar to that of the J.C.C., we believe that with its greater sphere of influence a body of opinion could have been built up strong enough to gain for it the goal of an Act of Parliament similar to that enjoyed by the dental profession.

Nevertheless, this outstanding event of the year, the establishment of friendly contact between the two main chiropodial organisations, is very welcome, but would have been more effective and useful to the profession had it occurred voluntarily and without external influence several years earlier. This would have given both sides time and opportunity for hammering out an acceptable common policy for the whole profession and thus prepared them in advance to meet any Medical Officer of Health. Any settlement under present conditions must, we fear, leave chiropody in a weaker position than if we ourselves had taken the initiative.

THE B.C.J. From the viewpoint of the editorial table another outstanding event of 1954 was the publication in June last of the 21st birthday issue of the B.C.J., when we were privileged to receive greetings and expressions of goodwill from many sources at home and overseas. This indicated beyond doubt that the journal, with its progressive and professional outlook and its concern for the future of the ethical members of the rank and file, has a definite rôle to play in the development of our profession.

The B.C.J. is indebted to all those who have contributed to its printed columns and it would be less than justice if one did not note the popularity of the monthly article by Mr. G. S. Mercer and the informative notes in "Round and

About" by "Vigilant". For its appearance and presentation great credit is due to the staff in the publishers' office and the prompt and efficient work of the printers.

We would draw attention to the fact that the B.C.J. is ready at all times to welcome and consider for publication articles from all sources dealing with anything of interest to chiropodists. Such contributions might, for example, deal with the conduct and results of personal or collective research, clinical practice, preferred methods and recorded results of treatment, theory of chiropody, drugs and their actions, chiropolitics, etc. Our invitation to submit articles is extended to our readers and their friends both at home and overseas; in fact to all who have something helpful to communicate to their fellow practitioners. Contributors would greatly help the editorial department by either using a typewriter or writing the article very clearly on one side only of the paper, leaving a wide margin on the left of page and allowing good spacing between lines.

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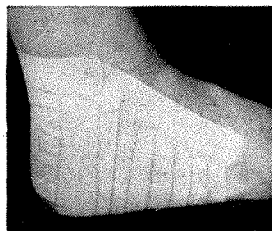
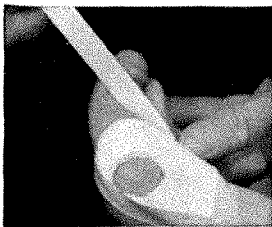
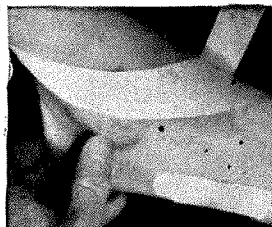
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NORMALITY AND ABNORMALITY in Foot and Footwear

By W. D. Watts, M.Ch.S.

To the mouse the tiniest stream is a mighty raging river, to the tumbler standing on his head in a rainstorm the rain falls upwards: if you wish to be rich, live next door to a pauper.

THIS apparently frivolous quotation from the Chinese proverbs is not included for its levity, but as a demonstration that comparison has been recognised as the yardstick in the measurement of values for many centuries. Our appreciation of the nature of things is dependent upon our comparison of every fresh encounter with previous recollection of 'sight, sound, smell, taste, touch or with' what we have been told by those who are able to offer comparison where we have none.

The demarcation between normality and abnormality is of necessity an arbitrary division and it is only because of a recognition and comparison of extremes that it is possible to make such a division. The innumerable subtleties of borderline variations cannot conclusively be designated to either side of the scale. This has contributed to the confusion of thought as to what constitutes normality, and the question of what constitutes a criterion for normality in the foot is inevitably raised.

To us the definition of the normal as being "according to rule" is unsatisfactory, since in a structure as fluid in its variability as the foot it is difficult to imagine such a standard. Further, the necessity for such a rule to embrace the static and active states increases the difficulty. That which may conform to such a preconceived rule in the static foot may prove inefficient or painful in activity. Thus the conception of norm-

ality as being in harmony with an æsthetic ideal which is probably non-existent in fact does not constitute an easily acceptable criterion.

Conversely, although a foot may be very different from the preconceived rule of structure it may well prove to be both painless and efficient functionally. However, although for practical purposes efficient and painless function might be cited as a test for normality, gross structural oddities, even though possibly obeying the preceding standard, cannot with firm certainty be labelled normal.

In our sphere it may seem that the practical test lies in the presence or absence of pain, but this too is not a completely adequate criterion, for immediate comfort does not preclude the possibility of future pain arising from identical structure in conjunction with varying environment. However, we must obviously have some standard of normality, and the definition which offends least and raises the least objection is probably the one which defines normality in relation to function.

In this connection the question of environment may be as important as the structure itself, and it would appear necessary to consider the normality or abnormality of the environment before convicting or acquitting the foot. In fact in our particular work this consideration is certainly a primary one, for it is often the action of "abnormal" environment, especially in the form of footwear, which disrupts the well-being of the intrinsically normal foot.

This leads us to the question of nor-

malinity in footwear and what constitutes the ideal or the desirable in this sphere. While we must accept any variety or curiosity of superficial design in footwear, we should be able to enumerate certain basic desirabilities in the fundamental form of footwear and we should be prepared to condemn with no uncertainty the undesirable features of prevailing design.

As has been stated, the most apt criterion for designating normality to a foot would seem to be adequate and painless function, and this is surely best achieved by interfering as little as possible with the structure and therefrom the function of the foot. Certain obvious necessities arise from this and should be mentioned although they are so obvious and self-evident that they are apt to be overlooked, ignored and finally are often replaced by more complicated theoretical facts and fancies. Essentially the best form of shoe is surely the one which permits the greatest freedom of pedal function. It does not matter what the type of foot may be; the preceding statement is axiomatic.

It has been suggested that a rigid soled shoe is preferable for the foot of Western civilisation, but this suggestion has dubious recommendations. We have been told that with the adoption of prepared, flat and hard walking surfaces civilised man has developed a stereotyped pattern of pedal function which reduces weight distribution to an unvarying pattern and therefore concentrates load heavily upon particular sites, and, as we know, these particular sites are frequently unable to bear this perpetual repetitive load.

Would we therefore improve the fate of the foot if we increased the constancy of this weight-bearing pattern by encouraging the rigid sole? Would it not be more desirable to use a pliable sole which would tend to stimulate versatility in weight distribution? Further-

more, we may question the premise that the shoe-encased human foot is becoming more rigid. Is there any evidence of increasing rigidity?

In practice we find the loose, unstable type of foot to be one of the most commonly encountered. In *The Chiropodist* of June, 1954, McBride quotes a survey which showed that of 100 "normal" adults 66 had weak and flat feet. That is to say, 66 out of 100 had *excessively* mobile feet.

It is true that in activity the foot is to some extent a rigid structure in that bones are transiently fixed and stabilised in certain positions by muscular action. That is a necessity of function, but it is as equally true in the naturally existing foot as it is in the civilised shoe-encased foot. In fact, the truly rigid feet which we see are structural oddities and it is the rigid type of foot which often exhibits distressingly painful and persistent pressure lesions which arise essentially from structural rigidity and the accompanying reduction in the shock absorbing capacity of the foot.

It has been said that we have need of rigid-soled footwear to protect our feet from the surfaces upon which we walk, but in the case of civilised man this reasoning is perhaps fallacious. The prepared surfaces of civilised communities are surely less likely to cause damage than the uncertain and inconstant environment of the naturally existing foot. It is reasonable to suggest that the foot which functions in a world of flat, even surfaces needs less protection from those surfaces than is the case in the foot which acts in a natural, and therefore in most cases hazardous, habitat.

The unfortunate question of fashion is also involved in the consideration of normality in footwear, and it has been maintained that certain concessions must be made to the inevitability of fashion in footwear, but to condone some of the

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features which the hierarchy and perpetrators of fashion trends choose to maintain would be to fail in a duty of our work.* Naturally we are not concerned with the superficial and innocuous features of fashion which do not affect function, but there are perversions in fashion which we should not hesitate to assault with all vigour.

To suggest that some fashion features are not harmful because they may be formative in creating a type of foot which is "natural" to its environment (i.e., to fashionable footwear) is to excuse the cause by justifying the evil which it produces.

This is particularly a curious reasoning when we see the many disorders which can be laid at the door of fashionable footwear. Are we to be content with and accept as natural to fashionable footwear feet which are painful and deformed? Are we, for instance, to accept as normal the retracted or clawed toes of the inveterate court shoe wearer in that they are a natural consequence of their environment? If we are, then we must also accept as normal the pressure lesions which may accompany the digital derangement.

Some male commentators are inclined to bow to the so-called inevitability of female fashions and to counsel its acceptance with the best grace, saying that we cannot succeed in convincing women of the desirability of "ideal" footwear because such footwear is usually "unfashionable," whatever that may be. But female fashions are curious phenomena and women do adopt extraordinary and unbecoming apparel if they believe it to be fashionable. The question of what makes a garment fashionable is, of course, an unsolved mystery, but we should never assume that the female sex will not accept a particular type of shoe because it is not at the moment fashionable. Furthermore, the possibility must

always be borne in mind that women's wearing of unsuitable but fashionable footwear may stem from an incomplete realisation on their part of what distressing symptoms may arise from wearing such footwear—for the majority are not fully aware of the unfortunate consequences of unwise footwear habits.

Many sufferers do not even seem to be fully aware of the fact that their foot disorder has in fact a cause. There seems to be a prevailing opinion that these disorders are something quite independent of any contributing influences, particularly in regard to environment. For instance, we are well acquainted with the patients who assure us that their shoes are quite comfortable, yet they consult us because their feet are painful. We also know what a difficult task it is to convince a female patient that she may need to wear larger shoes. It seems that pain and disorder in the feet are often regarded, as it were, as isolated states which are in themselves complete.

As we know, of course, pain and hyperkeratosis are symptoms and as such are merely a part of a whole state which has a cause. This we should emphasise, particularly when footwear is obviously to blame or is a contributing factor. This is a question of education and should be vigorously pursued. There is no point in minimising the consequences of unwise footwear habits; results in this direction will only be achieved by full-blooded and oft-repeated condemnations of harmful features.

In the sphere of fashion the first and most obvious factor which comes to mind is that arch-villain of fashion's cast—the raised heel. It is true that opinions differ on what constitutes a reasonable high heel and that some authorities may excuse heels up to a certain height, but as yet no really plausible case has been made to support the desirability of the raised heel for normal feet. On the other

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hand, a formidable indictment has been made against it—an indictment which cannot be dismissed lightly—and, as we know, the raised heel is one of the main bulwarks of fashion in women's shoes.

Fashion apart, the prevailing shoe sole shapes are not to be particularly recommended since they bear little relationship to the peripheral outline of the feet which they are reputed to fit. The discrepancy in form of foot and insole shapes is a fundamental one which should be remedied. The remedy rests largely, of course, with the manufacturers and to some extent with the anonymous and mysterious creators of fashion. It behoves us in our pre-eminence in this sphere to make our opinions quite clear to the circles concerned with the design and manufacture of footwear.

Another important feature of fashion which is sometimes overlooked is the decree that the feet should be small in proportion to body size, but in the majority of females the feet and the body are in proportion; thus the illusion of small feet is created by wearing shoes which are too small.

Accepting the fact that the feet are to be encased in footwear, it follows that for optimum pedal function it is neces-

sary for the footwear to allow functional freedom and a primary requisite for this is that footwear should retain an unintruding position without the aid of a special function of the foot. If a part of the foot is preoccupied in retaining footwear *in situ*, then freedom of function is impaired. This means that the shoe must be firmly anchored to the foot without impeding intrinsic pedal function; in other words the foot should have freedom of movement within the shoe, but the shoe should not be free to move about the foot in a way which may demand an activity of the foot in an attempt to stabilise its covering, and which may impair efficient function.

It would be foolish, of course, to lay the blame for all foot disorders upon footwear. As we know, there are a host of other extrinsic and intrinsic factors involved in the etiologies of pedal disorder, but it would equally be unwise to absolve from guilt footwear which is obviously damaging. We have only to consider the discrepancy of incidence of foot troubles in men and women and to compare their relative footwear habits to realise that there is in many cases an undeniable direct connection between foot disorders and certain footwear.

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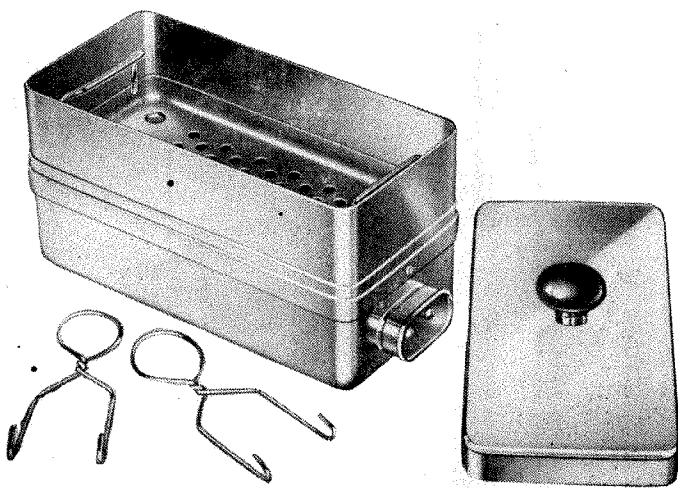
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THIS AND THAT

By G. Stanley Merter

BY the time this issue is in circulation most of us will be occupied with festive preparations for the Christmas holidays. Few will want to talk or read 'shop.' This fits in very well, as at this time of the year activity in the chiropractical world is more or less at a standstill, and in consequence, there is little of particular interest to write about. This contribution is likely, therefore, to be a sort of scrap book affair, touching upon this and that as it comes to my mind.

A few days ago I was talking to two chiropodists, who are partners, operating three foot clinics of the commercial type. They are worried men about the future of their establishments. They have made up their minds that if State protection comes, then "foot shops" (their description, not mine) as such will come to an end. Whilst I do not admire their methods of blatant commercialisation, I do admire their ready acceptance of the inevitable, without squealing. They accept the likelihood that by law they will be compelled to conduct their practices in accordance with a tight code of ethics, prescribed within the framework of official regulation.

Readers will have rightly assumed that neither of these practitioners are members of either the Society or Joint Council. Both have been well trained, however, but avoided membership of either body as they wanted to be free to indulge in publicity and display. Neither are they newcomers to the profession.

Can these men adapt themselves and their practices to the new methods which State protection may impose? Without the advantage of publicity and display can they successfully compete with their

more ethical professional brethren? They don't seem to think so.

I am not so sure about it. They should remember that whilst they may not be permitted to commercialise themselves, neither will anyone else. So far as conduct is concerned every practitioner will be required to toe the same line. If a practitioner knows his job and gives satisfaction he should be able to hold his own with anyone.

The question of fees was also touched upon during my chat with the partners. Did I think the regulations would provide for a minimum scale of fees, they asked. They pointed out that at the moment their charges were relatively low, but admitted that only a minimum amount of time was spent on each patient. If the law required them to put up their fees considerably, the class of patients they were dealing with could not afford it.

I explained that I was a strong advocate for the introduction of a minimum scale of fees, but I doubted very much if such a scale would form part of any official regulations. Although either directly or indirectly, doctors and dentists are protected by law, there is no official guidance as to the question of fees in private practice. And if and when State protection arrives for the chiropodial profession, I do not expect a regulation in regard to fees. In my opinion it is a subject which will find its own level quite satisfactorily without the application of hard and fast regulations.

THE SERIOUS DECLINE in the number of students taking up chiropodial training is a subject which is causing some considerable concern. The explanation can be found in a variety of reasons. It may

well be that prospective students are waiting to see which way the cat jumps. If I were a parent footing the bill for the training of my son or daughter, I should certainly wait until the future destiny of the profession had been determined by the authorities. Three years is a long time to keep, clothe, and provide the necessities of life for a youngster who would otherwise be productive in some other career whilst learning.

It has also been put to me that we are living in an unusually fast-moving era and most youngsters are attracted by a career which offers more excitement and action than chiropody. There may be something in this.

But I stick to my point expressed in an earlier article that the pitiful remuneration paid to chiropodists operating under the Health Service is the main cause for the half empty training establishments. I am aroused when I read the "official appointments vacant" columns of the journals. By present standards the salaries offered

are hardly sufficient to keep body and soul together. In my opinion the schools will remain half empty until the question of official salaries is vigorously tackled. A 50 per cent increase for all grades would not be too much.

I OBSERVE with interest the rapid increase in visiting practices. Many chiropodists are attracted to this kind of practice because it offers greater variety and is much healthier. The idea is made much easier by the large variety of portable equipment being offered by most suppliers, at extremely low prices.

It seems, however, that the successful practices are to be found in the better class country areas, where patients are in a position to pay fairly high fees to offset the time and cost travel involves.

AND SO that is all for this year. All that remains to conclude this article is for me to wish all our readers compliments of the season and a very happy and prosperous 1955.

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Round and About

by "Vigilant"



REFLECTIONS AND HOPES

MOST CHIROPODISTS I have questioned during the past week are not likely to mourn the passing of 1954. For the most part it has not been a particularly productive year. Practices have been generally quiet, due largely to the absence of anything resembling a summer season. A number of practices have also been seriously hit by cut-fee competition and free treatments provided by hospitals and municipalities. Hospital chiropractors have, however, been kept very busy and most of them more than earned their salary—or should I say pittance?

What of 1955? Will the various branches of medical auxiliary work, including chiropractic, become State Registered before the year is out, and if so, will it prove to be an advantage to the profession? I would not be bold enough to hazard a guess. All I know is that in such matters Government machinery is slow moving, and I confess to being a little nervous about a protective State Register which embraces all of the medical auxiliary services in the one Act.

HOW ARE THEY ABSORBED?

I UNDERSTAND that many of the short-period training establishments continue to turn out quite a number of newcomers to the profession. What happens to them? Because of the tight licensing

regulations operating in most areas, few of them are able to obtain the necessary licence to practise. It seems, however, that for the most part they obtain employment in an establishment already licensed, or take up visiting which so far as I am aware is unaffected by the licensing rules.

A HAPPY ENDING

A COUPLE of years ago I made reference in this column to a pending court action involving two practitioners arising from one's questioning the professional ability of the other. At my instigation the two settled their problem sensibly without resorting to law; in fact they became firm friends. They have now gone a step further and joined forces in a partnership. All best wishes for the success of the venture. Truly a happy ending.

THE GOOD SAMARITANS

ALL PRAISE to those chiropractors who, outside normal surgery hours, are treating old-age pensioners at a cost which barely covers the price of the dressings used. I know of one lady practitioner who devotes her weekly half-day to visiting and treating the old and infirm. Here we have the Good Samaritans of the profession.

OUR EDITORIALS

IT IS the job of our Editor to study and examine carefully all chiropractic

issues as they arise and publish his comments and predictions. This is no easy task. As a matter of interest I have refreshed my memory by glancing through our editorials over the past couple of years. There is something a little uncanny about the fulfilment of almost every prediction our Editor has made. I make reference to this only to emphasise to our readers how desirable it is to read the editorials, which might be sometimes overlooked.

WILL THE MINISTRY RELENT?

THOSE CHIROPODISTS and surgical apparel fitters who are under contract to the Ministry of Health for the supply of surgical hosiery did not take kindly to the Ministry's cut in the profit margin.

Representatives of the surgical trade

have been pressing hard for a restoration of at least part of the cut. I rather think their efforts may soon be rewarded. Readers should watch my future notes for further information in this connection.

A NEW CREST

IT IS OBSERVED that the Joint Council of Chiropodists have adopted a new crest. It is an attractive design with an appropriate meaning. I like it very much.

GREETINGS

THIS ITEM concludes my notes for this year. It is an appropriate opportunity, therefore, to convey to our readers my very best wishes for Christmas and the New Year.

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Radian-B, a spirit-based liniment containing *aspirin*, is indicated in the treatment of bruises, sprains and rheumatic pain.

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ABSTRACTS

From Our Contemporaries

Canadian Chiropody Journal.

FROM THE Editor's page:

It is not so much to be wondered at that the foot has never received the attention which has been bestowed on the hand. Aesthetic reasons may be partly responsible for this, even as they are for many other discrepancies. But even in the medical field where aesthetics would not play such a part, there is still a rather curious tendency for ailments of the feet to be regarded more casually than they should be. The foot has been referred to as one of the unexplored areas in medicine. It might even be called the Cinderella of our profession, except that her foot problem did happen to receive very special attention! In any case our profession seems to have been slow in encouraging the development of a speciality dealing with diseases of the feet. Morton, who can speak with authority, holds that "The foot is the only part of the body for which prevailing ideas of care and treatment have remained practically the same for forty years."

This anomalous state obtains chiefly in the field of minor ailments, so far as it may be correct to speak of ailments as being minor. A gangrenous toe will be the subject of intensive investigation by most skilled and experienced internists. But a sore foot or a corn, while admittedly less immediately serious, can still be a crippling condition for large numbers of people, and yet will not receive anything like the proportionate degree of skilled attention, by the same highly trained men.

Signs are not wanting, however, to show that the lag of which Morton complained is being gradually overcome. Not only are there more textbooks dealing with the foot, but chiropody is slowly but surely establishing itself. The chiropodist is no longer only someone who extracts corns, useful as that may be. He is now a trained professional man, with professional and ethical standards like our own, and based on rigid training. He undergoes four years of training, with high pre-academic requirements and is trained in the basic sciences of anatomy, physiology, pathology, etc. He specialises as does the dentist in a limited field of the body outside of which he does not venture.

Journal of N.A.Ch. (U.S.A.)

I AM very interested in shoe dermatitis. To gain the proper perspective of this subject, I believe it is important to recognise that sweating is a continuous secretion. During episodes of thermal sweating, there is a tendency for there to be less psychic sweating from the palms, soles, and axillæ; however, with the lowering of the thermal threshold, there occurs a compensatory outflow of so-called psychic or emotional sweat. A careful review of this subject in the past has disclosed that American physiologists have paid little, if any, attention to the subject of psychogenic sweat. In fact, two current monographs on this subject have been thoroughly reviewed, and no reference was found. I believe that we have overlooked a vital physiologic principle. Certainly, the ridicule would be great if we were to interfere with the secretion of tears, saliva, or bile, to say nothing of the kidneys. The importance of these physiologic principles is recognised, but just as important is the func-

tion of psychic sweating. It is most interesting to consider how we have violated this physiological principle. Present-day efforts are directed at trying to stop it. Thus we see a fair incidence of axillary dermatitis, and, of course, dwarfing this incidence is that of pedal dermatitis.

L. EDWARD GAUL, M.D.
Evansville, Ind.

It would seem obvious that in order to decide whether a particular drug is effective in preventing or curing a given disease, one should not only know what happens to persons receiving the drug, but also have some indication of what would have happened if they had not received the drug. Only if the drug favourably alters the natural history of a disease should it be considered to have a beneficial effect. This obvious fact, however, is frequently overlooked.

A recent article concluded, for example, that irradiation of the pituitary gland was of benefit to certain cases of arterial hypertension, because 62 per cent of patients so irradiated showed clinical improvement. Other authors, however, demonstrated that while 68 per cent of patients showed clinical improvement following irradiation of the pituitary gland, 78 per cent of patients not receiving the treatment showed clinical improvement. The latter authors recognised that in order to interpret results of irradiation as beneficial, they must show not only clinical improvement in some patients, but clinical improvement on a greater scale than if no irradiation were given.

THE FOLLOWING is a simple and painless method for avulsion of any nail. This procedure may prove beneficial in any number of different ungual conditions such as advanced fungus, infected nails, onychocryptosis, and for the exposure

to surgically excise subungual tumours.

It is common knowledge that a nail will loosen and separate cleanly after injury severe enough to produce a large subungual hæmatoma. The following is a procedure which duplicates this natural process and I might add is indicated only when it is desirable to remove the nail plate in total mass and not the entire ungual matrix.

The digital nerves are blocked and the tourniquet is applied. Hyaluronidase of 100 Turbidity Units per cc. of distilled water is now injected under the distal of the nail. Injection of the hyaluronidase is started after the 25 gauge needle has penetrated one-fourth inch. Keeping the needle in constant contact with the plantar surface of the nail plate, advance the needle slowly and continuously injecting the hyaluronidase. Usually 2 cc. of the liquid is sufficient. The fluid spreads quickly, breaking the cement substance which binds the ungual bed. After a few minutes, gentle traction is used to completely avulse the nail. Bleeding is minimal and the procedure is practically painless.

Australasian Chiropodist

YOUR CUSTOMER :

He is usually a person suffering under some pain of disability from which he wishes to be relieved, and to be relieved speedily; but who seldom wishes to make any change in the ordinary course of his life, or in the ordinary conditions of his activity. He has, say, papilloma; and he regards the chiropodist chiefly as an agent whose business it is to remove this condition, and who, if he be of competent skill, will remove it without delay, and without insisting upon any tiresome conditions, or upon any inconvenient sacrifices. Next, perhaps, to the desire to be "cured," to be relieved without loss of time of the particular inability or discomfort which is experienced at the

moment, comes the wish of the average patient to be told what is the matter with him, and then, what is the "cause of it." It must not be supposed that he has any wish to be initiated into the physiology of his organism, but he wants to be put into possession of a name, the name of some recognised "complaint" which he may spread abroad for the information of his friends. Almost any name will do; but as a rule, the longer it is the better it is liked.

Chiropody Record (U.S.A.)

From a lecture by Dr. W. Barry Ave, of Chicago.

There are many factors peculiar to the foot which cause disability of that organ, to mention a few:

1. The foot being the most distal portion of the body, the circulation is poorest.

2. The foot is most vulnerable to injury.

3. The 26 bones which make up the skeleton of the foot are irregular in shape and have numerous projection points, each of which may become a fulcrum for friction, pressure and irritation.

4. The foot assumes more weight than any other part of the body.

5. The foot is not constructed to withstand being enclosed in shoes of leather and strong fabric.

6. The greatest percentage of footwear is ill-fitted.

7. Modern civilisation requires us to stand on hard surfaces most of the time which nature had not intended or prepared us for.

8. Anthropologically, the anatomy and function of the foot has modified as much or more than any other part of the body. For example, the intrinsic muscles (those which originate and terminate in the foot and number 13) have lost most of their intended function, but play an important rôle in causing deformity. All the normal functions of our foot are performed by the muscles in our leg.

10. The very common disease known as varicose veins occurs in the legs, thereby involving the foot.

11. Many of the congenital deformities (those which children are born with) occur in the foot.

12. Many common infections such as ringworm are habitants of the foot.

13. The foot has received the least amount of consideration and research from medical science.

9. General diseases of the arteries usually manifest themselves first in the feet.

QUERIES

Answered by F.A.D.

Q *Can you give some help regarding sulphonamide drugs and their reaction to ultra-violet rays?*

What period of time should elapse between the taking of these drugs and exposure to U.V.R.?—W. N. D.

A In order to give authoritative replies to the above queries I have consulted two authorities on such matters and here are their replies.

Dr. William Beaumont, M.R.C.S., L.R.C.P., author, and Director of Physical Medicine, Westminster Hospital, London, says:

The administration of sulphonamide drugs may render a patient 'light' sensitive. It does not always follow, but it is a wise precaution not to combine the two.

The manifestations are a rash and maybe a rise of temperature.

Should ultra-violet irradiation inadvertently be given to a patient who, unknown to the operator, is having sulphonamide,

there should be a lapse of at least fourteen days after the last administration before ultra-violet irradiation is given. I would point out that those remarks apply particularly to general ultra-violet irradiation, but may not apply to very localised conditions of the foot. [I would point out that Dr. Beaumont's routine teaching is that skin tests should be taken in all cases prior to commencing irradiation by U.V.R. in order to ascertain correct dosage.—Ed.]

Another authority consulted replies as follows:

Sulphonamide is a skin sensitiser; that is, the reaction to ultra-violet rays would be more marked than usual.

For example, where normally there is an erythema "1" reaction to an E1 dose, in the case of a patient taking sulphonamide there might well be an "E2" reaction to an "E1" dose. Pre-

cautions should be taken to carry out careful skin tests before and during the course of treatment and the dose given should be usually less than the usual dose. As far as I understand no clear reason is known why sulphonamide increases skin sensitivity to U.V.R. I imagine one should wait a week at least after cessation of sulphonamide before giving normal doses of U.V.R. and even then only after carrying out preliminary skin testing.

From these replies it will be seen that skin sensitivity due to administration of sulphonamide may persist beyond the period of its administration and that the competent operator has it in his hands to prevent accidents by taking the usual skin tests. It should not be forgotten that skin sensitivity to U.V.R. varies quite considerably in normal cases, quite apart from the action of any drug.

CASE NOTES

THE following case notes are submitted by Mr. E. S. Smith, M.Ch.S., 14 Lord Street, Gainsborough, Lincs.

The patients are brother and sister; Mr. B., aged 74 years and Miss B., aged 70 years.

1. Mr. B. Circulation poor. First toe (r) nail very slight O/AUX. Attended January, 1954, on routine 5 weekly visit.

O/E toe nail was separating from free edge, medial border, and there was exudation of serous fluid from under the nail. The nail was removed to within $\frac{1}{4}$ in. of the base, exposing an ulcer approximately $\frac{1}{4}$ in. in diameter in the centre of the nail bed. No pus was present.

The patient had felt no pain since his last visit, on which occasion no abnor-

mality was detected. The ulcer was packed with gauze and furacin and healed well within 14 days.

The nail plate now is fully grown and normal.

At first it was thought that the ulceration was due to a sensory or vascular disturbance, but such ulcers are usually indolent, and healing in Mr. B's condition was fairly rapid.

2. Miss B. Circulation poor. Varicose veins some years duration. Both legs.

First toe nail (r.) normal, texture very good, attends at 14-day intervals, attended September 11 c/o painful toe nail, first (r.).

O/E nail separating from free edge, pressure on nail plate expelled small amount of serous fluid.

Through the nail plate a small erythematous area approximate $\frac{1}{4}$ in. in diameter was visible in centre of nail bed. Removal of the nail exposed

a small mass of hypergranulation tissue attached by a pedicle to the nail bed.

This was excised and the base touched with copper sulphate and dressnig applied. 7 days later resulting eschar was removed and a lanolin dressing applied. The nail is now growing again quite normally.

Both patients were instructed to use emollients until the nails had again reached normal length.

There was a similarity in the two cases insofar as the (r.) first toe nail was affected. There appeared to be no exciting cause, and there was no infection (sepsis). Although the patients are brother and sister, I hesitate to suggest a familial etiology. A possibility is that a third member of the family suffered from onychia 2 years ago, again on first (r.), but in this case there was a well advanced O/AUX.

• If, as I first thought, the ulceration was due to a sensory or vascular dis-

turbance, this must only have been transitory, otherwise I believe the ulcer would have taken much longer to heal.

Case notes of two patients are presented and comment as to possible cause would be welcome.

In neither case was there a history of conscious trauma, i.e., stubbing of or dropping weighty object on toe.

The distal phalanx was not hyperextended, as would be expected if trauma were caused by pressure of toe on shoe toe-cap. In any case, pressure from this direction, I believe, would be negligible as the shoes were of ample dimensions, in the case of Miss B., two sizes too large, to accommodate crepe bandages.

There was no noticeable lengthening of the foot on weight bearing and no foreign bodies were present.

Up to the dates mentioned there had been no previous trouble with first (r.) toe nails.

LETTERS

The Editor welcomes letters on any aspect of the Chiropodial profession. The views expressed do not, of course, necessarily represent those of the Journal.

LETTERS MAY BE PRINTED UNDER A PSEUDONYM IF DESIRED, BUT NAME AND ADDRESS OF SENDER (NOT FOR PUBLICATION) MUST BE SUPPLIED.

ELECTING COUNCILLORS

SIR,—It is my considered opinion that the present system of electing councillors to the Society of Chiropodists is quite adequate for the time being. There is no need to vote for the full amount of vacancies, and I only vote for the one or two that I actually know are likely to support my viewpoint.

The majority of voters always place their faith in those members of council who have already served a term of office; practically all vacancies are caused by resignation or death, and again practically

all new councillors are those who are proposed by eminent members holding office on council. We have a classic example this year which proves my point.

It is reasonable to suppose that nobody has any strong views in any direction until they reach the council stage of finding out what solemn and secretive matters are discussed when they meet. It would be very unwise for any prospective member of council to voice his opinion in public unless he is quite confident of his ability to support his ideals afterwards.

Circumstances suggested that it would be much healthier for me to lie dormant for awhile, and but for the fact that 348 members still regard me with a measure of interest, I should not have written this letter. I can claim to be quite unique in being the only prospective candidate whom nobody has ever wished to nominate; having reached this stage on my own any

offer must be a good one!

T. HAROLD DARLINGTON, M.Ch.S.
Swansea.

The fact that Mr. Darlington only knows the views of one or two candidates surely demonstrates the need of a change of system. Surely among the remainder there is the possibility that others hold similar views and may be more capable of putting them forward. One should not be so limited in choice.

If, indeed, the contentions in his second paragraph represent the truth then it is a grave reflection upon the system which by its limitations renders the possibility of change and progress very remote.

If prospective members of parliament followed the line of his third paragraph the people would have no idea where to put their X on their voting papers and would leave the unknown to the obscurity to which they belong. Mr. Darlington has done us this. Candidates should have ideas of their own and should be prepared to submit them to the members they seek to represent. That way lies enlightenment and progress. Through not being acquainted with a man's views we may risk leaving a chiropodial Churchill, Eden, Butler, or Schweitzer in unjustifiable perpetual obscurity.—ED.

FOOT HEALTH WEEKS

SIR,—Continually in chiropody and other medical journals reports on Foot Health Weeks or Foot Safety Weeks are given prominence and publicity. Yet these propaganda campaigns are organised and instituted by the footwear manufacturers and their associations and federations, who have but one object in view, and that certainly is not foot health. Some of the atrocities which are sold as footwear, and can be seen in any shoe shop, are ample proof of that. A greater and more far reaching publicity is used to-day,

but the use of the medical cloak in order to sell the goods is an old line of sales talk. That is neither our worry nor concern as chiropodists, but, when this business is getting unpaid publicity and prominence in chiropody journals, it is time to take notice.

Firstly, the number of assistants in shoe shops who have had even elementary training in fitting is negligible, yet all are efficient salesmen and women. Their use of the X-ray fitting machines was the work of a psychological genius, as they have no more idea as to what they are looking at than the customer. The only thing that matters is that the customer is satisfied. That makes them good sales people, but is this quite sufficient qualification to run a Foot Health Week?

It is debatable whether the chiropody organisations have no desire, or lack either the initiative or the unity of the footwear manufacturers to organise a proper foot health week, or perhaps lack the willingness or enthusiasm to assist or co-operate fully, with the footwear manufacturers to make such a campaign a true Foot Health Week, with benefit to both sides.

Cannot our profession make up its mind? This middle course, this publicity in our journals, is in effect giving support by professional approval and recommendation to a campaign which, with the medically cloaked name removed, is obviously only a publicity sales campaign for footwear, not being in the least concerned with the health of the feet—that being the customers' concern.

I can only conclude by quoting a recent report in *The Western Evening Herald*. It gave details of a gathering of shoe-shop managers in a Plymouth hotel, during which, one said: "I must sit down a minute George; my feet are killing me!"

R. F. HARTLEY, M.S.S.Ch.

NOTES AND NEWS

Visit to Shoe Factory

A PARTY of two-year students, taking a three-year course in chiropody at the London Foot Hospital, visited Norwich recently to tour the Norvic Shoe Works. They were accompanied by Mr. M. D. England, senior lecturer at the hospital.

They devoted most time to seeing the results of research and tests which have gone into the making of children's shoes.

Mr. Ralph Colman, assistant managing director of the Norvic Shoe Company, showed them a selection of footwear showing development in design, shapes and manufacture over the last fifty years. He also told them that shoe manufacturers were anxious that when they went into practice they should use their knowledge to guide and advise the public about what was good and what was bad for the nation's feet.

Foot Clinic Moves

THE FOOT CLINIC for old age pensioners, started three months ago by members of Bromley, Kent, branch of the Red Cross, has now been moved to a room at the county headquarters in Mason's Hill, Bromley.

The Welfare Officer of the Bromley Division, Mrs. J. M. Bolton, said recently that the clinic had been a great success and that they were booked right up until after Christmas.

Providing Chiropody Service

REPLYING to a question in the House of Commons recently, the Minister of Health said that local authorities could, with his approval, provide a chiropody service, or contribute to a voluntary organisation for this purpose, as part of their arrangements for the prevention of illness, care and after-care, under section 28 of the National Health Act, 1946; but in present financial

circumstances he was unable to approve any extended direct provision of the service. They could at their discretion make arrangements for chiropody at homes provided under part III of the National Assistance Act, 1948, for persons in need of care and attention not otherwise available to them, by virtue of the definition of accommodation in section 21(5) of the Act as including, so far as might be necessary, other services, amenities and requisites.

Hereditary Aspect of Bunions

MR. H. H. RAWLINGS, M.Ch.S., took part in a recent Brains Trust at Kingswood, Somerset, Grammar School on the subject of foot health.

Mr. M. P. McCormack, F.R.C.S., speaking on the subject of bunions, said they were definitely hereditary, and there was little to be done about them save the choosing and wearing of sensibly fitting shoes.

Mr. Rawlings agreed and said it was more important for shoes to be long enough than wide enough. The panel of speakers agreed that women, in particular, should choose their shoes to fit comfortably rather than from the fashion point of view.

Cost of Chiropody Scheme

IN THE HOUSE OF COMMONS recently, Dr. B. Stross, Member of Parliament for Stoke-on-Trent Central, asked the Minister of Health how many local health authorities had made representations to him with a view to the provision by him of chiropody services, particularly for old people, and whether he would give an estimate of the cost of such provision to the whole of the country.

Miss M. P. Hornsby-Smith, Parliamentary Secretary to the Minister of Health, replied that sixteen authorities

and approached the Minister and the national cost would be about £1,000,000 annually. There were higher and more urgent priorities at the present time, she added.

Coins in a Fountain

THE PUBLIC at Kettering, Northants, were invited recently to help start a chiropody service for old people in the town by throwing coins into a fountain, erected by council workmen outside the Town Hall.

The scheme was devised by the Deputy-Mayor of Kettering, Alderman George Howard, and the manager of a cinema in the town during the showing of the film, "Three Coins in a Fountain."

Unsuitable Shoes Worn

SIX THOUSAND workers in Slough, Bucks., have had to report for foot treatment to Slough Industrial Health Service, because of badly worn and ill-fitting shoes.

This was revealed recently in the annual report of the service, and Mr. G. A. Strtridge, the chiropodist employed by the service, estimates that 60 per cent of these are women.

The causes of the foot ailments were the suitable shoes worn by many women in factories.

Adjustable Child's Shoe

MRS. ALICE BUXTON, liaison officer to the Foot Health Education Bureau and the Central Council for Foot Health Education, has returned from New York with some samples of American children's footwear. One example, which aroused interest on her return, was a house bootee which to remove from the foot completely snaps out and has adjustable snap fasteners to vary the width according to growth of child's foot.

Chiropody for the Old

THE FOOT CLINIC for the old people in Southwark, London, benefited from

the proceeds of a Dickens Fair held recently at the Manor Place Baths, Southwark, London, S.E.1.

THE PROVISION of a chiropody service for old people was again discussed at a meeting of the Milnrow Old People's Welfare Committee, held recently in the Council Chamber, Milnrow, Lancs.

It was decided to request the assistance of the Nursing Association.

A ROOM has been allocated for the chiropodial treatment of the old people of Otley in the Day Nursery, The Licks, Otley, Yorks., by the County Council.

Dr. H. Wolfe stated at a meeting of the visiting committee of Otley Old People's Welfare Committee, recently, that he would be pleased to hear from any chiropodist in the district who would be willing to attend.

THE CHIROPODY service for old people in Exeter has proved a success, with the latest applicant an old lady of 90. This was stated at a meeting of the executive committee of the Exeter Council of Social Service at the Council of Social Service Hall, Exeter, Devon, recently.

THE POSSIBILITY that a foot clinic operating at a charge of 1s. 6d. for the treatment of both feet might be provided for the old people of Clapham was stated by Mrs. O. Haines, chairman of the Wandsworth Old People's Welfare Council in an address at Clapham Baths, Clapham, London, recently.

THE EXTENSION of the cut-price chiropody scheme for old people of Cheltenham to Beurtan-on-Water, Glos., recently, followed the announcement that the British Red Cross Society had taken over the chiropody scheme in the rural areas around Cheltenham from the Old People's Welfare Committee. The Red Cross, who are expanding their scheme to cover a larger area, also planned an extension to Chipping Campden.

CLASSIFIED ADVERTISEMENTS

The cost of Classified Advertisements in "The British Chiropody Journal" has been reduced to 2d. per word, minimum 3/-; Box Number 6d. extra.
Address: Advertisement Manager, The British Chiropody Journal, 356-358 Kilburn High Road, London, N.W.6

The engagement of persons answering advertisements must be made through a local office of the Ministry of Labour, or a scheduled employment agency, if the applicant is a man aged 18 to 64 inclusive, or a woman aged 18 to 59 inclusive, unless he or she, or the employment, is exempted from the Provisions of the Notifications of Vacancies Order of 1952.

SITUATIONS WANTED

LADY CHIROPODIST, L.Ch., 9 years' experience, available 2-3 days weekly. Essex/City/West End areas preferred.—Box No. B.C.J. 599, 356/358 Kilburn High Road, London, N.W.6.

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FOR SALE

SURGERY closing due to increased activity by the L.C.C. Municipal Foot Clinic. All equipment for sale: any offer will be considered for whole or part.—Write Box No. B.C.J. 589, 356/358 Kilburn High Road, London, N.W.6.

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LONG-Established Practice in Glasgow, good-class clientele, average takings over £1,000. Low overheads. Audited accounts available, must sell, offers, only genuine enquiries.—Box No. B.C.J. 598, 356/358 Kilburn High Road, London, N.W.6.

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